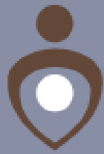

Working With Communities.

# Children under 12 years with Sexual Behaviour Problems in London and Middlesex County: Trends and Professionals' Perceptions

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# Children under 12 years with Sexual Behaviour Problems in London and Middlesex County: Trends and Professionals' Perceptions

## FINAL REPORT

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# Executive Summary

In recent years there has been signs of a concerning trend in children's behaviours in London and Middlesex County. More children than ever are being identified as having Sexual Behaviour Problems. These children (many of whom are 12 or younger) exhibit age-inappropriate sexualized behaviours in their social interactions and play with other children. Community professionals working in the fields of child protection, children's mental health, health services, education, and parents are raising concerns about the nature and possible increase of children's sexual behaviours that they have witnessed in their professional practices, classrooms and in unstructured settings such as playgrounds and family residences. In addition, lack of appropriate and accessible treatment resources for these children has been identified as an issue.

Clinicians working with children have expressed concerns related to this increasing trend and the main concern relates to the safety of these children. There is a strong correlation between sexual acting out behaviours in children and being a victim of child abuse, particularly sexual abuse. In fact, the presence of sexual behaviour problems in children is one of the few reliable indicators of possible sexual abuse as well as possible exposure to inappropriate adult sexual behaviours or adult sexual material.

### *Current Study*

The current study was conducted to learn more about sexual behaviour problems among children under the age of 12 and the community's response to these behaviours. The study included an intensive file review of 20 child protection files for children who have been identified to have sexualized behaviour, as well as a survey of professionals. Surveys were completed by 110 social service professionals and teachers, and included questions about perceptions of the problem and community response.

### *Trends and Prevalence Estimates:*

Results of the surveys with social service professional found that 16% –33% of boys and 12%-31% of girls in the community are estimated to have sexual behaviour problems. Teachers and day care staff estimates ranged between 20-25% of boys and girls. Approximately 50% of community professionals reported their perception of an increasing trend in these behaviours. Sexualized behaviours reported in case files showed a wide range of behaviours, ranging from sexualized language to self-stimulation and penetrative types of behaviour. Most identified children engaged in multiple forms of sexualized behaviour.

### *What do we know about these children?*

The file review part of this study found that children with sexual behaviour problems experience chaotic family environments. Results show strong patterns of child maltreatment including physical, sexual and neglect. In their living environments these children have often witnessed or been directly affected by a range of factors known to adversely affect child development, including:

- domestic violence
- alcohol and substance abuse problems
- unstable living arrangements
- different and often temporary caregiving figures
- adult sexual activity and pornography
- poor parenting skills
- poverty

These children were also identified as having co-morbid problems such as Attention Deficit Disorders, Oppositional Conduct Disorders, attachment disorders and in a few cases psychological disturbances related to trauma, compulsive behaviours and attachment problems. Many were reported to be functioning below their developmental level despite having normal intellectual capability.

Many of the children's caregivers had histories of abuse including childhood sexual abuse, maternal depression, and were frequent victims of domestic violence and woman abuse. The biological fathers for the most part had little interaction with their children and had histories of violent behaviour. Many of these children had lived in alternate care by being placed with friends, neighbours, or in foster care.

It was apparent that sexualized behaviour is only one of many problems in the lives of these children. Their behaviours are at least partly a reflection of the chaos in their lives. It is critical to address the family system as a whole when providing services and treatments to these children. It is also equally critical that the children who were targeted be identified and offered services to address their victimization and other safety issues.

### *Implications of the Sexualized Child Behaviour:*

Clinicians expressed concerns about the risks that these children pose to themselves by their inappropriate behaviour in terms of physical injuries, emotional and psychological vulnerability. Sexually provocative children may be at increased risk for sexual victimization. In addition, these sexualized social interactions and play cause emotional harm to other children who are exposed to these age-inappropriate and sometimes sexually aggressive behaviours.

### *Barriers to obtaining services:*

Clinicians expressed concerns that the community's current response is inadequate, or even harmful. There was widespread concern for these children being identified as sexual perpetrators. In addition to being developmentally inappropriate, these labels carry a stigma of social delinquency and may have serious negative consequences for these children as adolescents and adults.

There is a dire need for services and treatments for this population of children that are easily accessible, affordable, and developmentally appropriate. Currently services for this population are limited and many children are falling through the cracks. Professionals identified a range of service barriers including:

- eligibility criteria for services
- services are not publicly funded
- services that do exist are not easily accessible or capable of meeting the needs of all the children in this population
- long waiting lists
- services that are primarily designed for adolescents and are inappropriate for children

The implications of inadequate treatments poses short-term risks to safety as well as potentially serious long-term consequences, including relationship difficulties, risky lifestyles and more serious consequences such as involvement with the criminal justice system during adolescence and adulthood.

### *Response from Community Professionals:*

Community clinicians expressed feeling inadequately trained to assess and treat this problem. Teachers have a big responsibility to ensure that their classrooms are safe and yet have received no training to deal with this problem and no protocol on how and when to report these concerns. There was an overwhelming response with 88-96% of professionals asking for more training opportunities.

### *Summary and Recommendations:*

There is great concern among teachers and social service professionals about children who act out sexually. This community needs to acknowledge this problem publicly, and provide effective and accessible treatments and services for these children and their families. Teachers, school staff and other front-line workers require educational resources, training, and professional support to help them address this problem as it arises. Finally, as a community we need to support these children and their families with accessible and affordable resources, adequate services and work to remove the negative labels and social stigmas.

## Overview

Although sexual acting out in children is widely regarded as a concerning behaviour, surprisingly little is known about the children who engage in these behaviours. Perhaps in part because the topic of childhood sexuality causes significant discomfort among adults, there is a significant gap in community awareness about the problem and appropriate community responses to these children. The purpose of this report is to summarize the findings of two studies that investigated these issues. The first study, consisting of an in depth file review of 20 child protection files of children who were identified with sexual problem behaviours, provided a description of the children, their families, the incidents of sexualized behaviour, and other pertinent issues. The second study, consisting of survey data from 110 front-line professionals from a variety of agencies including child protection, children's mental health, school boards, police etc., explored issues such as perceptions of sexualized behaviours in children, perceptions of trends, available community resources, and gaps in training.

This report contains a brief overview of the typical and atypical developmental trajectories for sexual behaviour in children, differences between children who act out sexually and adolescents or adults who offend, and some of the factors associated with sexual problem behaviours in children. Next, the studies are described in terms of methodology and findings. Finally, general themes and recommendations are presented.

## Normal and Abnormal Childhood Sexual Development

Defining normal sexual behaviours in children is complex because normal sexual behaviours have to be defined at each age and developmental level. For example, while it may be normal for a 3 year-old to take off his clothes or touch his genitals in public, the same behaviour in a 13-year-old would be cause for concern. In general, normal behaviours reflect the biological and intellectual developments of children and follow a developmental progression. Typically, children will explore and interact at a level that they are biologically, intellectually, emotionally and socially prepared for. Sexual behaviours in children serve several important developmental functions. These behaviours provide a way for children to acquire information about their bodies. They also allow children to explore differences by looking and touching themselves and others. Sexual behaviour also facilitate and exploration of gender roles and behaviours as part of children's sexual socialization (Johnson, 1998). Indeed, sexual play and interactions between children is considered normal and healthy:

- ✓ when the children involved are of similar age, size and developmental status;
- ✓ when participation is mutual and voluntary;
- ✓ when the sexual play behaviours are not excessive or harmful; and,
- ✓ when the play behaviours are limited in type and frequency and the children's interest in sex; and,
- ✓ when sexuality is balanced by curiosity about other aspects of their life (Johnson, 1998)

In contrast to the normal, healthy and developmentally appropriate sexual play described above, sexual behaviour problems differ in terms of intensity, intrusiveness, and impact. Johnson (1998) has identified sexual behaviours that raise concerns because of their age-inappropriateness, social inappropriateness and/or because the behaviours themselves are physical and emotional harmful to the children involved. Johnson has identified 20 characteristics of child sexual behaviours that should raise red flags for adults. These indicate sexual behaviours that are not healthy or

developmentally normal for children. Sexual behaviours in children may be considered problematic when:

- ✓ the children engaging in the sexual behaviours are of different ages or developmental levels;
- ✓ sexual behaviours are a source of emotional warmth or a way to cope with loneliness;
- ✓ children have too much knowledge about sex and engage in adult sexual behaviours;
- ✓ sexual behaviours are impulsive, progressive and persist over time and are associated with or driven by anxiety, guilt or fear and is a way to cope with overwhelming feelings;
- ✓ sexual behaviours are eliciting complaints and/or adversely affecting other children and are socially inappropriate
- ✓ play is limited to and demonstrates a preoccupation with sex or sexuality;
- ✓ children sexualize non-sexual things, interactions, relationships and engage animals;
- ✓ sexual behaviours cause physical or emotional pain or discomfort to self or others;
- ✓ when sex is used to hurt others and is paired with anger and aggression;
- ✓ children do not understand their rights or the rights of others in relation to sexual contact and use distorted logic to justify their sexual actions; and
- ✓ coercion, force, bribery, manipulation or threats are associated with sexual behaviours

A more detailed list of problematic sexual behaviours is in *Appendix A.*

In describing the boundary between healthy and unhealthy sexual behaviour in children, Johnson and Gil (1993) have proposed a continuum from normal and healthy sexual behaviours to molesting types of behaviours. They have developed a typology to conceptualize different patterns of sexual behaviours in children 12 years of age and younger. The importance of this typology lies in the realization that different patterns of problematic sexual behaviour have different contributing factors, and may require different responses from the adults involved. The four types identified include normal sexual exploration, sexually reactive behaviours, extensive mutual sexual behaviours, and children who molest. Each of these categories is described briefly below:

***Normal Sexual Exploration*** involves age-appropriate curiosity about bodies, sexuality and play that explores each other's bodies (playing doctor) and exploring gender roles and behaviours (playing house).

***Sexually Reactive Behaviours*** reflect age-inappropriate knowledge about sex and sexual behaviours. It usually is a re-enactment of experienced inappropriate sexual contact or exposure to adult sexual activities/ media.

***Extensive Mutual Sexual Behaviours*** constitute a more pervasive and focused sexual behaviour pattern than sexually reactive children. They participate in the full spectrum of adult sexual behaviours. While they may use persuasion, they typically do not use force or coercion to elicit participation from others.

***Children who Molest*** demonstrate sexual behaviours that go far beyond what is developmentally appropriate childhood exploration and play. These children are often preoccupied with sex, physically and sexually aggressive, and generally have poor impulse control. They also engage in adult sexual behaviours and typically use force, coercion, threats or manipulation and trickery to elicit participation from same-aged or younger peers.

Children who engage in molesting types of sexual behaviours pose a greater risk to the peers they interact with than those children whose sexual acting out behaviours are reactive in nature and confined mostly to their own bodies. Children who molest are sometimes seen as 'sexually offending' other children because of the age-inappropriate nature of molesting behaviours and the force, coercion, and aggression involved. Is it appropriate to label a child who molests, with adult criminal labels like, 'pedophile' or 'sex offender'? The first author of this report has been present at child abuse conferences where case studies of "ten-year-old pedophiles" are presented. We would argue that applying these adult labels is extremely problematic and that assessment within a developmental context is necessary. There are critical differences in the developmental level of children that make their behaviours different from the behaviours of adults - physically, intellectually, emotionally, socially and morally.

## Sexual Acting Out: Children Vs. Adolescents / Adults

Although sexual acting out in children has some superficial similarities to adult sexual offending, there are critical differences. Sexual offending behaviours in adults and adolescents imply socially deviant or inappropriate sexual behaviours directed towards non-consenting individuals. These are most often criminal behaviours because they are carried out against the will of the victim and often paired with violence, force, threats to the individual's safety or the safety of those close to them. Unlike most adults and adolescents, children are developmentally not capable of the same kind of intellectual capacity for reasoning, planning and knowledge about the implications of their actions, as adults and adolescents.

Perhaps the biggest difference between adults/adolescents and children in terms of sexual behaviour is what they hope to achieve with their behaviour. Despite the severity and degree of sexualization of the behaviours, children are not engaging in these behaviours to seek sexual gratification of their sexual needs and desires. Rather, children are often seeking love, attention and emotional warmth that is lacking in their lives or responding to overwhelming feelings of anxiety, guilt or fear and sexually act out as a way to cope with their overwhelming feelings (Johnson & Gil, 1993). When children's emotional needs are not met by their caregivers they often turn to peers and/or other adults. Physical contact provides comfort to these otherwise neglected children and they are often likely confused and associate physical touch and contact with love and caring. Children who are sexually misused or exposed to adult sexuality are more apt to associate sexualized actions with love and caring (Johnson & Gil, 1993).

In contrast, sexual offending adults and adolescents engage in sexual behaviours primarily to seek sexual gratification, and often use violence, force, coercion, threats or manipulation to make sure these needs are met. Most adults/ adolescents are also intellectually capable of discerning right from wrong, capable of the reasoning to plan and execute their actions sometimes using complex schemes to force, coerce, manipulate or trick people into sexual activity with them.

## What Predicts Sexual Problem Behaviours in Children?

Research in this field suggests that many boys and girls who act out sexually have witnessed adult sexuality paired with violence, been sexually, physically and emotionally abused, and

experienced significant neglect of their physical and emotional needs by their primary caretaker (Friedrich, 1990; Friedrich, Davies, Feher, & Wright, 2003; Gil & Johnson, 1993; Silovsky & Niec, 2002). Child maltreatment is very strongly correlated with sexual behaviour problems.

Other dynamics that possibly influence sexual acting out behaviours in children include exposure to highly stimulating sexual content in terms of printed media, TV, pornographic materials, viewing other adolescents/adults involved in various sexually stimulating behaviours (including viewing parents during love-making, sexualized language, picking up on the sexual content of constant sexual innuendos in sexualized families) (Johnson & Gil, 1993). Dysfunctional family dynamics including overt and covert abuse, criminal or illicit activity, incestuous patterns of interactions, emotionally barren families, families where children have had to take on a care-giving role and families with poor boundaries have also been implicated in the development of sexual problem behaviours (Johnson & Gil, 1993).

Finally, other associated characteristics (which are not necessarily causal) have been identified. These include: Loss/ disruption of early attachments, panic and anxiety, impaired self-regulation, excessive/ unfair punishment, Oppositional and Conduct disorders. From a functional perspective, children may use sexually inappropriate behaviours to 'get back' at others, to express anger or pent-up aggression, or to provoke reactions in an attempt to seek attention even if it is punishment. In older children and adolescents, sexual behaviours may sometimes be used to assert power or domination or to manipulate other children (Crenshaw, 1988).

To summarize, sexual acting-out behaviours in children under 12 years raise concerns because of their age-inappropriateness, deviance from socially acceptable norms, and risk of harm to the children involved. Furthermore, these behaviours may indicate another problem that lurks beneath the surface, in that they are risk markers for various forms of abuse. Although sexual acting out behaviours do not equate having been sexually or physically abused, they are certainly grounds for taking a closer look at what is transpiring for a particular child or family.

### Will sexually abused children grow up to be sex offenders?

One of the biggest concerns regarding sexually abused children who exhibit sexualized behaviours is the fear that these children will in turn perpetuate the cycle of victimization by becoming perpetrators themselves as adolescents or adults. Children who engage in molesting and sexually aggressive behaviours present the biggest concern and are often considered to be at a greater risk to sexually offend in later years than those children who are abuse-reactive. However, research identifying this intergenerational transmission of sexual acting out is preliminary and tends to rely on indirect evidence.

On one hand, research shows that 35% of adolescents reported for the sexual abuse of a child had themselves been victims of childhood sexual abuse, physical abuse or neglect. The prevalence of childhood sexual abuse among child molesters in a clinical outpatient treatment sample ranged from 21% to 25% (Jonson-Reid & Way, 2001). Among adults convicted of sex crimes, about 30% began offending as children, some before they were 9 years old. On the other hand, according to Johnson (1998) only 0.5% of sexually abused children will go on to molest other children. These statistics are only estimates, given the widespread under-reporting of child sexual abuse.

According to these various findings, there is a link between childhood sexual abuse, sexualized behaviours, and sexual offending later in life. However, the strength of the association ranges

depending on the methodology of the study and the sample being used. Thus, while a sizeable minority of adult sexual abusers have histories of childhood sexual abuse, most victims of child sexual abuse do not grow up to offend sexually. Appropriate interventions for children who have been sexually abused or who are demonstrating sexual behaviour problems may be a critical factor in determining the different outcomes that we see for different children.

## Current Study

Community professionals in London-Middlesex County working with children in the areas of child welfare, abuse and neglect have expressed concerns that the numbers of children who are exhibiting sexual behaviour problems appear to be an increasing trend. These children are engaging "in sexual behaviours beyond their age and stage of development and who are emotionally harming other children through their sexually aggressive behaviour" (Topham, 2003). According to child protection staff, this observation is also starting to be expressed by family doctors and medical professionals that have treated children or had families raise this concern with them. Front-line protection workers report that teachers and day-care staff have also noticed that the numbers of children exhibiting these behaviours in the classroom and schoolyard are increasing. Finally parents too are raising more concerns than ever before about the sexualized play behaviours of the children they encounter at playgrounds or in the neighbourhood as documented by phone calls to child protection agencies. Consequently the children's mental health centres are addressing more cases of children with sexual behaviours now than before, even if the sexualized behaviours are not the primary reason for referral. As a community, there is concern that little is known about these children and their intervention needs. Furthermore, concern has been raised about a gap in appropriate and accessible services for children who have sexual behaviour problems.

In response to these community concerns, the Child Abuse Council of London-Middlesex formed a research subcommittee. This subcommittee, under the leadership of Ms. Amanda Topham, MSW, submitted an application for a community grant. The grant was approved by the Centre for Research on Violence Against Women and Children at the University of Western Ontario, and researchers from the UWO were contracted to undertake the project. The project involved a collaboration between the research subcommittee and the university researchers at every step of the process, including procedures, measures, and written documents. The research sub-committee consisted of representatives from the Children's Aid Society of London and, Child and Adolescent Centre at London Health Sciences, Madame Vanier Children's Services Middlesex, and the Child and Parent Resource Institute (CPRI)

The primary aims of the study were to:

1. Investigate the trends and perceived prevalence of children with sexual behaviour problems in London and Middlesex County
2. Explore the associated characteristics of children who exhibit these problem behaviours
3. Ascertain the perceptions of the community professionals, with an emphasis on possible gender differences among children who have sexual behaviour problems
4. Explore the current treatment and service responses available to this population of children within the community

# Study 1- File Review

The first part of the study consisted of a file review of children aged 0-12 years who were residing in London and Middlesex County at the time that they were identified as having sexual behaviour problems. The purpose was to gather descriptive information about children who act out sexually (index children), their relationships to the children they act out towards (target children), circumstances surrounding the incidents of sexualized behaviour, and services offered.

## Method

Participants for this part of the study were children who had exhibited problematic sexual behaviours between the dates of January 1, 1999 and December 31, 2003. Children's files were identified by social workers at the London-Middlesex Children's Aid Society. Inclusionary criteria included residence in London-Middlesex County at the time of the sexualized behaviour incidents and being 12 years or younger at the time of incident(s). Exclusionary criteria included identified developmental disabilities (IQ less than 70) to control for reduced /impaired developmental growth as a confound. Twenty comprehensive files were reviewed.

A data collection tool consisting of three parts was used to collect data from files. This tool included:

- Case Data Sheet -- used to record demographic information and case history
- Episode Sheet -- used to document information regarding sexualized behaviour in file
- Service Dispositions – used to document what services and treatments were offered

The data collection tool was developed specifically for this study and is included in *Appendix B.*

A Data Coding package was used to provide a uniform means of recording collected data. Items on the Data Coding Package were a combination of new items and items adapted from The Child Sexual Behaviour Inventory (version 1; Friedrich, 1990), and are included in *Appendix C.* All protocols received ethical clearance from The University of Western Ontario's Medical Review Board prior to the commencement of data collection.

## Results

The main purpose of collecting data from file reviews was to identify the underlying dynamics and associated characteristics of sexualized behaviours in children. In reviewing the 20 child protection case files, we encountered a wide range of family backgrounds, associated familial problems and other behavioural problems of these children (in addition to their age-inappropriate sexual acting out). In all cases there were a number of problems faced by these children, and their age-inappropriate sexual behaviour was only one of many concerns faced by their families.

The results will focus primarily on addressing the following questions:

1. Children who act out sexually– Who are these children in this community?
2. What was the nature of the sexual behaviour problems exhibited by these children?
3. Who are the other children who are being targeted or victimized by inappropriate sexual interactions?
4. What community services/ treatments were available and offered to address this concern?

## 1. Who are these children?

For the purposes of this study, children who have been identified as having exhibited sexual behaviour problems will be referred to as the "Index Children". Of the 20 case files reviewed 13 index children were male and 7 were female. Their dates of birth ranged from 1986 –1997. It should be noted that by definition, these children represent a high risk group within the larger population of children who act out sexually in that their living circumstances have been identified to constitute child protection concerns.

### Victimization History of Index Children:

Findings from this study revealed that virtually all of these children had a documented history of some form of abuse or had witnessed abuse and domestic violence. Six of the seven girls had recorded histories of being sexually abuse, six had been physically abused, and four neglected. For boys, eight of the 13 had sexual abuse histories, 12 had been physically abused, and 10 had documented histories of neglect. In virtually all cases, the perpetrators were people in positions of trust with the children. In this sample of 20 children, perpetrators of sexual abuse were most likely to be adolescent male babysitters, perpetrators of physical abuse were most likely to be biological fathers, and perpetrators of neglect were most likely to be identified as biological mothers. The finding that mothers were most likely to be implicated in neglect was in large part an artefact of the number of single parent mother-headed families. This pattern also reflects a social bias whereby mothers are more likely than fathers to be charged with neglect, even in two-parent families (Trocme, et al., 2001).

### Index Children's Living Arrangements

Living arrangements of these children involved complex and constantly changing configurations. Over 40% of the identified index children resided in single parent households headed by mothers. Other people (mothers' boyfriends, parents' sexual partners, family friends etc) who were not part of the immediate family were also present in these households. In some cases, children were shuffled back and forth between custodial and non-custodial parents, or alternatively, between parents and foster care or group home placements. Table 1 reflects the living arrangements of the index children at the time of sexualized incidents.

Table 1: Living Arrangements of the Index child

| Caregivers of the child | Percentage of cases |
|---|---|
| Both biological parents | 4.9 % |
| Single parent –biological mother | 41.2 % |
| Biological mother + common-law partner/ boyfriends | 5.9 % |
| Biological father + common-law partner/ girlfriends | 5.9 % |
| Foster family | 17.6 % |
| Residential Treatment home/ group homes | 23.5 % |

## 2. What was the nature of the sexual behaviour problems?

Children's recorded sexualized behaviours ranged across a spectrum from sexual curiosity and mutual sexual play to more intrusive sexual acts that were sometimes accompanied by force, coercion or physical threats. Table 2 lists the various Sexual Behaviours and indicates the numbers of boys and girls who have engaged in these behaviours.

Table 2: List of Sexual Behaviours

| | Details of Sexualized Behaviours | (N= number of children who have engaged in sexual behaviours) | |
|---|---|---|---|
| | | Boys N=13 | Girls (N=7) |
| Gender Identity | Talks about wanting to be the opposite sex | 0 | 1 |
| | Male child using fists under shirt to simulate breasts | 1 | 0 |
| | Male child asks for female clothing and under-garments | 1 | 0 |
| | Male child wants and steals girls' makeup | 1 | 0 |
| Sexual Language | Uses explicit words to describe sex acts | 1 | 3 |
| | Makes sexual sounds (moans, sighs, heavy breathing etc) | 2 | 0 |
| | Talks about sexual acts | 4 | 1 |
| | Written sexualized language | 1 | 2 |
| | Makes sexual comments, statements or gestures | 1 | 1 |
| Self-Stimulation | Touches own private parts when in public places | 3 | 0 |
| | Masturbates with hand | 2 | 0 |
| | Masturbates with objects | 1 | 0 |
| | Touches own private parts when at home | 1 | 0 |
| | Rubs body against people or furniture/ trees | 3 | 1 |
| | Masturbation in public or with other children | 5 | 1 |
| | Excessive masturbation | 0 | 1 |
| | Requesting sexual devices/ aids for masturbation | 0 | 1 |
| Heightened Sexual Interest | Imitates the act of sexual intercourse | 3 | 3 |
| | Asks other to engage in sexual acts with him/her | 4 | 2 |
| | Tries to look at people when they are nude or undressing | 2 | 2 |
| | Imitates sexual behaviour with dolls or stuffed animals. | 3 | 1 |
| | Tries to view pictures of nude or partially dressed people (may include catalogues and printed material). | 2 | 0 |
| | Asks to view nude or sexually explicit TV shows (may include video movies or HBO-type shows) | 3 | 0 |
| | Tries to watch adults engaged in sexual activity | 2 | 0 |
| | Tries to enter shower/ bathrooms/ bedroom when others are using the facilities or nude | 3 | 2 |
| | Tries to look up women's skirts or down necklines | 1 | 1 |
| Exhibitionism | Undresses self in front of others | 7 | 4 |
| | Shows private parts to other children | 3 | 2 |
| | Stripping/ Dancing in an exotic manner | 3 | 1 |
| | Exposes private parts in public to children / adults | 8 | 1 |
| | Prefers to be nude when at home | 1 | 0 |

| | | | |
|---|---|---|---|
| Sexual touching | Touches others private parts | 9 | 5 |
| | Puts mouth on another child's or adult's sex parts | 5 | 1 |
| | Tries to undress other children or adults against their will (opening shirts, pants etc) | 5 | 0 |
| | Sexual play/ exploration with other children | 2 | 2 |
| | Laying on top of other children during sexual behaviour incidents | 3 | 1 |
| | Physically aggressive when kissing | 2 | 0 |
| | Kicking/ hitting other children in their private parts | 2 | 0 |
| | Tries to get into other children's beds at night | 1 | 0 |
| Penetrative Sexual Behaviours | Inserts or tries to insert objects in his/her own vagina or anus | 1 | 2 |
| | Inserts or tries to insert objects into someone else's vagina or anus | 2 | 0 |
| | Inserts penis into someone else's mouth | 2 | 0 |
| | Tries to penetrate an animal or tries to have the animal penetrate him/her. | 1 | 0 |
| | Inserts penis into objects | 2 | 0 |
| | Has engaged in sexual intercourse | 0 | 3 |
| Other Sexual Behaviours (specify) | Tries to make other children urinate in public or on each other | 2 | 1 |
| | Tries to make another children urinate in his/her mouth | 1 | 0 |
| | Tries to drink urine | 1 | 0 |
| | Toileting concerns (smearing feces, urinating/defecating in odd places, soiling other people's possessions etc) | 5 | 2 |
| | Sexualized drawings | 2 | 1 |
| | Tries to lick other children's faces | 0 | 1 |

It is noteworthy that all of the major categories identified by Johnson (i.e., sexual language, self-stimulation, heightened sexual interest, exhibitionism, and sexual touching, penetrative sexual behaviours and other sexual behaviours) were exhibited by at least some of the twenty children whose files were reviewed. The data in the previous table reflect only verified numbers of *children* who have engaged in these behaviours and not the number of sexualized *incidents*. Frequencies of specific acts were typically not reported – thus, a behaviour may have been exhibited on one occasion (but brought to the attention of adults who reported it), or a behaviour may have been a frequently occurring act.

Furthermore, the amount and detail of information about sexualized behaviour varied greatly among files. Because there is no standardized information protocol, some files have extensive detailed information and others were sparse. Indeed, the Data Coding Sheet developed for this project was far too detailed to be completed for most of the files. Thus, the information presented is likely an underestimate in terms of types of frequencies of sexualized behaviours.

### Associated Characteristics

Chart information was also coded to look at associated characteristics of sexualized behaviour, including locations where sexualized activity occurred, whether force, coercion or threats were used, and whether there was an adult present at the time of the sexualized behaviour incidents.

### Use of Coercion or Force

In 10 out of the 20 cases of children the index child had used force, coercion or physical threats to elicit cooperation or participation from the targeted children. Of the 10 children who had used force, coercion or threats, 8 of these were boys. Thus, there was a significant gender difference in that 8/13 boys used force compared to 2/7 girls. These numbers reflect reports that the index child has used force, coercion or some form of intimidation to elicit cooperation/participation on at least one occasion; however, the number of times force or coercion was used was not measured.

### Presence of Adults

In 68.8% of the cases at least one adult was present and witnessed the sexualized behaviours. Of these children whose sexualized behaviours were witnessed by an adult, 8 were male and 3 were female. Although this percentage seems high, there is likely a strong reporting bias in that many sexualized behaviours that are not witnessed by adults are likely never reported.

### Location of Sexualized Behaviour Incidents

Locations of sexualized activity included both public and private venues. Furthermore, the sexual behaviours took place somewhere familiar to the children. Table 3 shows a list of locations where sexualized behaviours occurred. Overall, the result indicate that sexualized behaviours can occur in virtually any location where children spend time together.

Table 3: Locations where Sexualized behaviours occurred

| Locations | Number of known incidents of Sexual Behaviours |
|---|---|
| Shared bedroom | 4 |
| Common living areas of the house | 9 |
| Classroom | 2 |
| Schoolyard | 5 |
| School bus | 2 |
| Family bathrooms | 5 |
| Public bathrooms | 2 |
| Community recreational facilities | 1 |
| Buildings other than those on family property | 1 |
| Other (residential treatment home, neighbourhood, women's shelter, day camps) | 11 |

## 3. Who are the children that are victimized?

There were significant gaps in the identification of the target children, their relationships to the index children, their living arrangements and especially what services (if any) were offered to this group. Data that were available suggested that accessibility may play a large role in determining which children are targeted. That is, children seem to act out with children that are known to them and with whom they spend time. In some cases, the line of distinction between who was the perpetrating index child and who was the target child was clearly defined. In other cases, the line between index and target child(ren) was more fuzzy, partly because some of the

sexual interactions appeared to be more mutual in nature and partly because there seems to be a cycle of victimization involved in that targeted children may subsequently victimize others.

Table 4 shows the relationships between the index child and the target child. These data are a significant underestimate of the number of target children involved in that there was very often no data identifying the relationship between the index and target children. Based on the data that were available, we see a range of relationships in which sexual behaviour problems can emerge.

Table 4: Relationship between Index child and Target child

| Relationship between Index and Target children | N = number of targets (known) |
|---|---|
| Biological whole siblings | 11 |
| Biological half-siblings | 6 |
| Foster siblings | 3 |
| Classmates/ school acquaintances | 4 |
| Fellow residential treatment home members | 5 |
| Other (neighbourhood kids, group home members, other friends, team mates etc.) | 16 |

## 4. What community services were offered to Index Children?

Community Agencies in London & Middlesex county that were involved with these 20 children as service/ treatment providers and those agencies directly involved in a care-giving/ relief capacity for this group of children are listed below in Table 5. As the files were accessed through Children's Aid Society, it is a foregone conclusion that all 20 of the children had involvement with that agency. Other agencies included a range of treatment and support services.

Table 5: Community Agencies

| Community Agency | Number of cases involved (out of the 20 cases reviewed) |
|---|---|
| Children's Aid Society of London & Middlesex | 20 |
| Madame Vanier Children's Services (MVCS) | 14 |
| Child & Adolescent Centre (LHSC) | 7 |
| Child & Parent Resource Institute (CPRI) | 7 |
| Merrymount Children's Centre | 6 |
| Other | 5 |

## Methods of Assessment and Treatment for Sexual Behaviour Problems

File reviews indicated a range of assessment and treatment approaches. The following methods/ tools were used specifically to evaluate index children's sexual behaviour problems within the 20 files reviewed:

1. Generalized psychological testing and evaluation (used to identify a wide variety of concerns)
2. The Decision Matrix Risk Assessment of Sexual Perpetrators – Sten & Monetti (from text: "Treating Adolescent Sex Offenders in the Community")
3. The Child Sexual Behaviour Check List (CSBCL) – Toni Cavanaugh Johnson (1992)
4. The Family Roles, Relationships, Behaviour and Practices II Checklist - Toni Cavanaugh Johnson (1992)

The research subcommittee of the Child Abuse Prevention Council felt that some commentary was indicated with respect to the aforementioned assessment approaches. Specifically, the first strategy (generalized psychological testing and evaluation) does not specifically pertain to sexualized behaviour, and may have been part of a comprehensive treatment plan for children with multiple needs. The second assessment approach mentioned was designed for adolescents and is developmentally inappropriate for children under 12. Although the last two strategies are specific and developmentally appropriate, the committee felt that it was important to convey that these strategies represent the most minimal attempts to provide basic safety planning for families.

Similarly, a range of treatments/ services offered through the community agencies were identified in the files. The following list indicated the various services to which children were referred. The agency involved is indicated in parenthesis. Overall, the number of referrals suggests that these children have a high impact on the service sector. Furthermore, the nature of the services to which these children were referred suggests that children have other issues that need to be addressed, that specific services for sexualized behaviour do not exist, or some combination of those two factors. Indeed, most of the services listed below are not specific to sexual behaviour concerns. The services specifically designed to address sexualized behaviour concerns are italicized. Services included:

1. *Dual Diagnosis Program for psychological testing, evaluation of Sexual behaviours and counselling (CPRI)*
2. *Groups (pre-teen and latency age) for children who act out sexually (Children's Aid Society)*
3. *Child Abuse Intervention program for evaluation and referrals (Children's Aid Society)*
4. *Individual counselling with a sexual abuse therapist (Children's Aid Society)*
5. *Childhood Sexual Abuse groups (Children's Aid Society)*
6. Play therapy and art therapy (Madame Vanier Children's Services)
7. Residential Treatment program for sexual abuse issues (Madame Vanier Children's Services)
8. COPE Kids group and ARC group (Madame Vanier Children's Services)
9. Psychological/ mental health evaluation (Child & Adolescent Centre; CPRI)
10. 'Theraplay' and anger management sessions (Madame Vanier Children's Services)
11. Group for the parents of children who act out sexually (Children's Aid Society)

12. Psycho-educational parenting group to address behavioural issues (Children's Aid Society)
13. Play therapy and individual counselling/therapy for parents and children (Children's Aid Society)
14. Child Witness Project offers support to victims (Centre for Children and Families in the Justice System of the London Family Court Clinic)

There are two important notes to accompany the preceding list. First, item #2 (groups for children who act out sexually, that were offered by the Children's Aid Society) were part of a short-term pilot project. One child group and one parent group were offered, but the initiative did not receive stable programmatic funding. Second, this list represents services that were available for referrals during the timeframe under study (i.e., January 1999- December 2003). An additional service has been developed during that timeframe (2000) at the Child and Adolescent Program of the London Health Science Centre.

In addition to formal treatment referrals, some of the files reviewed contained other recommendations to intervene with sexualized behaviours. These were recommendations made to Front-line workers as temporary safety planning solutions while other services were being sought. The research committee noted that these consultations services have historically been provided by one or two professionals at the Children's Aid Society, and do not represent a widely available service. These recommendations included:

1. Consultation to de-sexualize home environments
2. Consultation to create home safety plans
3. Educational materials provided to parents (re: children's sexual behaviours and parenting techniques)
4. Education for children (re: healthy sexuality, good touch /bad touch education, coping skills to deal with sexual urges, education about disclosing abuse etc)
5. Home safety planning (includes: close supervision; setting clear house rules; use of baby monitors, door chimes, and installation of alarm systems and motion detectors.)

### Summary of Findings for Study 1 – File Review

The purpose of this study was to describe children with sexual behaviour problems and their behaviour through review of available documentation at the Children's Aid Society. As documented in these children's files, their experience was not limited to their own abuse and victimization, often included witnessing a family member (usually their biological mother) being victimized or violently abused in one form or another. Although we did not originally seek to record the victimization histories of the children's caregivers, we noticed patterns of violence, physical abuse and prior sexual abuse among the mothers of these children who are exhibiting sexualized behaviours.

The sexualized behaviours exhibited by these children were quite varied and ranged across a spectrum from different stages of sexual curiosity about their own bodies and other people's bodies to age-inappropriate heightened awareness of sexuality to more concerning behaviours restricted to their own bodies and at an extreme end of the spectrum to some extremely concerning behaviours that coupled sexual acts with aggression, force, coercion and threats. In 10 out of the 20 cases the index child had used force, coercion or threats to elicit cooperation in sexual activity. Although the sample was small, boys were more likely than girls to use coercion and threats. There were no other significant gender differences evident.

In general these children seemed to be living in chaotic environments in which they have witnessed and/or experienced considerable amounts of violence, abuse, neglect. The family circumstances often involved little stability in the children's living and school arrangements, broken families, financial and personal hardships for the parents, lack of appropriate adult supervision and in some cases sexualized home environments, alcohol and substance abuse. In this regard, sexual behaviour problems were but one of many difficulties exhibited by these children, and part of a complex picture of high needs families facing many challenges.

# Study 2 – Survey of Community Professionals

The second phase of the study was a survey of community professionals and front-line workers. This part of the study included a survey and questionnaire format in which community professionals were invited to participate in this study by responding to a survey designed to gather information on community professionals' perceptions of the problem in London and Middlesex community, and to share their understanding of services and resources available in the community for this population of children. Specific areas of inquiry included perceived prevalence of the problem, understanding of services available for this population of children, and perceived gaps in community responses.

## Method

Staff from Children's Aid Society, several children's mental health agencies, a day-care, residential treatment homes, and the London Police Services were invited to participate in this part of the project. Participants were contacted through their respective agencies or organizations.

The surveys and questionnaire was developed for the current study in conjunction with an advisory committee from the local Child Abuse Prevention Council. There were two versions of the survey, one is a *Survey for Teachers and Other School Staff*; the other version is a *Survey for Front-Line Staff,* included in *Appendices E* and *F,* respectively. The surveys include demographic information about respondents; questions about the respondents' perceptions of the problem and estimated prevalence in the community; questions about their perception of the causes and future implications for these children; questions highlighting their understanding of available services in the community; and a request for their comments and recommendations for services and training.

Participants were also asked to indicate their level of concern for 40 different sexual behaviours. The items on the questionnaire were adapted from The Child Sexual Behaviour Inventory (version 1; Friedrich, 1990). Professionals were asked to rate the behaviours once for boys and once for girls. There were two versions of the survey – one specifying boys and girls aged 1-6 years and the other specifying boys and girls aged 7-12 years. Copies of both versions are appended in *Appendices G & H respectively.*

As with Study 1, all protocols received ethical clearance from The University of Western Ontario's Medical Review Board prior to the commencement of data collection.

## Results

### Respondent Characteristics

There were 110 surveys completed by professional respondents. Twenty- eight participants responded to the Teachers and School Staff survey and 82 responded to the Front-line survey. For both groups of respondents, females outnumbered males at least 4:1. Among front-line workers 85.9% were female, and among teachers and school staff 80.8% were female. The ages of the participants ranged from 20 to 60+. Level of education ranged from Grade 13 to PhD among front-line workers. For teachers and school staff, the range was from a college diploma to Masters degree. In terms of employment setting, 39% of respondents worked for child protection services, 30% worked in a children's mental health centre, 6% worked in a day-care facility, 5%

worked in a hospital, 5% were employed by police services, and the other 15% worked in residential treatment homes or in a combination of work settings.

The results of Study 2 address the following issues:

- Sexual behaviours deemed most concerning
- Estimated prevalence of sexual behaviour problems in the community
- Professionals' perceptions and reactions to this problem
- The community's resources – current services and recommendations

### Most Concerning Behaviours

Respondents were asked to rate their level of concern for both boys and girls in relation to forty different sexual behaviours. There were no significant gender differences in the level of concern between boys and girls, although this finding may be a result of the structure of the survey. The five sexualized behaviours that raised the most concern for both boys and girls are shown in Table 6. Not surprisingly, respondents indicated that sexual behaviour that was intrusive, involved other children, and included coercion or force was most concerning.

Table 6: Sexual behaviours deemed most concerning by respondents

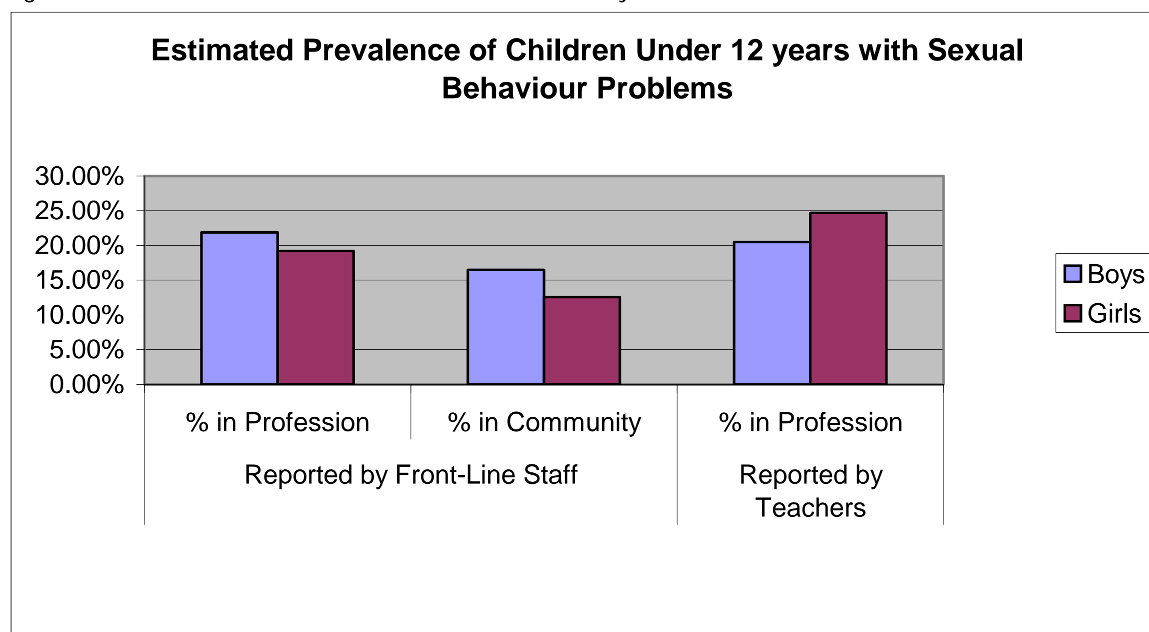
| | Boys | Girls |
|---|---|---|
| Ages 1-6 years | 1. Puts mouth on another child's/ adult's sex parts<br>2. Tries to insert objects into someone else's vagina/ anus<br>3. Tries to insert penis into someone else's mouth<br>4. Tries to engage an animal in sexual acts<br>5. Restraining another child and demanding sexual contact | 1. Puts mouth on another child's/ adult's sex parts<br>2. Tries to insert objects into someone else's vagina/ anus<br>3. Tries to engage an animal in sexual acts<br>4. Restraining another child and demanding sexual contact<br>5. Asks others to engage in sexual acts with him/her |
| Ages 7-12 years | 1. Puts mouth on another child's / adult's sex parts<br>2. Tries to insert objects into someone else's vagina/ anus<br>3. Tries to insert penis into someone else's mouth<br>4. Tries to engage an animal in sexual acts<br>5. Restraining another child and demanding sexual contact | 1. Puts mouth on another child's/ adult's sex parts<br>2. Tries to insert objects into someone else's vagina/ anus<br>3. Tries to undress other children/ adults against their will.<br>4. Tries to engage an animal in sexual acts<br>5. Restraining another child and demanding sexual contact |

### Estimated Prevalence of Sexual Behaviours:

Community professionals and teachers were asked to estimate the prevalence of sexual behaviour problems in children under 12 years based on their experience. Results showed significant differences in the reports of estimated prevalence between the two professional groups. Across settings and genders, estimates ranged from 12% to 25%.

Within the context of children with sexualized behaviour that professionals have encountered in their professional practice, estimates ranged from approximately 12% to 25%. Interestingly, front-line staff reported higher numbers of boys than girls, but teachers indicated the opposite trend.

Figure 1: Estimated Prevalence of Children under 12 years with Sexual Behaviour Problems.




## Perceptions of an Increasing Trend

Respondents were asked to estimate whether the numbers of children with sexual behaviour problems represents an increasing trend, a decreasing trend, or if the prevalence of sexualized behaviours among children has remained roughly the same as 10 years ago. Results indicated that close to half of the front-line staff and teachers perceive an increasing trend with more boys and girls acting out sexually as compared to 10 years ago. Approximately 25-30% of respondents in both groups indicated that they did not know what the situation was like 10 years ago and could not make a comparison. Most of the remaining 20% felt that the problem was the same as 10 years ago. Interestingly only 1 front-line respondent indicated a decreasing trend.

## Professionals' Perceptions of Sexual Behaviour Problems in Children

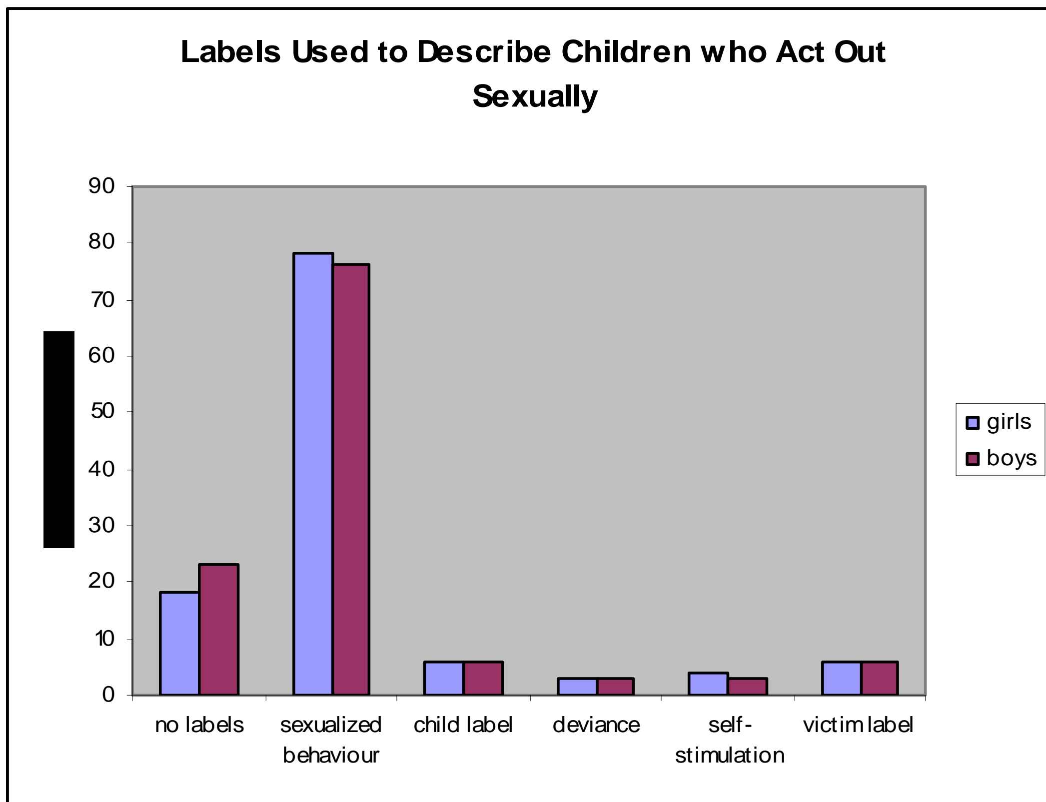
Due to concern about the manner in which children with sexual behaviour problems are conceptualized or described in the community, respondents were asked about labels they would use to describe this behaviour. This questions was asked to directly address the perception that children under 12 are being described with adult-offender terminology and concepts.

## Labels used for Children with Sexualized Behaviours:

In the professional surveys we specifically asked respondents what labels or terminology they would use to describe a child who is sexually acting out when talking to another professional. The majority of respondents refrained from using a descriptive noun to label the child and instead they labelled the specific sexualized behaviours that the children had engaged in.

Approximately 20% of respondents chose not to identify any labels. Responses were coded into one of five categories. These included sexualized behaviour (labels that focused on behaviour and used nonjudgmental language); child labels (e.g., perpetrator, molester); deviance (any label using the word deviance); self-stimulation (labels that focused on the masturbation or self-stimulating nature of the behaviour); and, victim labels (labels that emphasized children's victimization, such as 'victim reactive behaviour'). Many respondents provided more than one answer to this question. The percentage of responses in the various categories is depicted in Figure 2. There were no clear children gender differences in terms of labels identified by respondents.

Figure 2: Labels used to describe children with sexual problem behaviours




## Causes of Sexual Behaviour Problems:

Respondents were asked to identify the causes or predisposing factors for children's sexual behaviour problems. Results indicated that although there were some gender differences the causes were seen to be more similar than dissimilar for boys and girls. Respondents identified a wide range of predisposing factors that are consistent with the research in this area. Factors included individual, family, community and media influences (see Table 7 for responses).

Table 7: Causes / Predisposing Factors of Children's Sexual Behaviour Problems.

| Boys and Girls | Boys Only | Girls Only |
|---|---|---|
| Abuse | Sexually abusive families | Sexualized families |
| Exposure -inappropriate situations | Limited intellectual functioning | Disorders |
| Inappropriate exposure -media | Media exposure- sexual violence against women | Lack of positive female role models |
| Exposure/ witnessed sexual acts | Parents with sexual abuse history | Need for acceptance |
| Peer pressure | Past victimization | Lack of support |
| Familial concerns | Sexualized society | Increased sexual behaviour on TV |
| Need to feel loved | Lack of engagement in pro-social activities | Female TV role models sexually exploiting their bodies |
| Neglect | Conduct disturbance | Obsessive-compulsive behaviours. |
| Lack of impulse control | Witnessing abuse | Lack of parental warmth/ attachments |
| Developmentally normal curiosity | Hormonal changes | Lack of empowerment |
| Family's denial of abuse | | Familial violence with control issues and disrespect to women |
| Family dysfunction | | Exposure to 'risky' caregivers |
| Lack of parental supervision | | |
| Attention seeking | | |
| Attachment disturbance | | |
| Domestic violence | | |
| Poor role-modelling | | |
| Lack of appropriate boundaries | | |
| Parents with emotional/ mental health issues | | |
| Sexualized environment | | |
| Developmental or attachment issues | | |
| Parental separation | | |
| Poverty | | |
| Single-parent families | | |
| Intergenerational cycles of abuse | | |
| Past sexual trauma | | |
| Low self-esteem | | |
| Societal acceptance of sexualized behaviour | | |
| Sexual stereotypes in marketing | | |
| Inappropriate/ sexual parent-child interactions | | |
| Exposure to sexuality in media (TV, movies and music) | | |
| Lack of/ poor social skills | | |
| Psychological issues | | |
| Exposure/ access to pornography | | |

## Consequences of Inadequate Intervention

Respondents were asked to identify future concerns and implications for these children if they are not provided with adequate and appropriate services to address their behavioural problems. Results indicated that respondents worried about a wide range of outcomes, including perpetuating the cycle of violence, difficulties in relationships, mental health difficulties, and social problems. Table 8 lists the responses to the question of future concerns and implications.

Table 8: Future concerns/ implications if these children are not provided with services

| Boys and Girls | Boys Only | Girls Only |
|---|---|---|
| Will become sexual predators | Difficulty forming relationships | Become an abuser |
| Continue the cycle of perpetration | Sexually abuse others | Vulnerability |
| Become perpetrators / victims | Cause pregnancies | Promiscuity |
| Risk of STDs | Increased aggression | Victimization |
| Become sexual offenders | Psychosis | Alienation |
| Involvement in criminal system | Problems at school | Risk – unwanted pregnancy |
| Rejection | Inappropriate sexual attitudes | Low productivity |
| Mental health issues | Pedophile | Placing self at risk of violence |
| Isolation | Peer–victimization | Multigenerational cycle of abuse |
| Life-long guilt | Self-identity issues | Eating disorders |
| Depression | Substance abuse, addictions | Risk – Multiple sexual partners |
| Risk for suicide | End up in jail | Sexually 'loose' |
| Self-esteem issues | Become Rapists/ Sex Offenders | Become stripper |
| Prostitution | Suspensions from school | Model these behaviours for future children/ as parents |
| Street youth | Pervasive/ entrenched sexual behaviours | Become runaways |
| Abusive adults | Risk for causing pregnancy | Mental health issues due to internalizing |
| Act out sexually with other children | Increased risk of jail detention/ criminal status | Risk for not making good choices about mates |
| Interpersonal and Relationship difficulties | Pedophiles | Risk for isolation |
| Negative developmental impacts | | Risk for sexual abuse/ victimization |
| Greater likelihood of being out of home (welfare) | | Young mothers |
| Continue to victimize others as children/ adults | | |
| Risk for addictions | | |
| Promiscuity | | |
| Risk for violent relationships | | |
| Violence | | |
| Aggression and hostility | | |
| Rejection by peers/ community | | |

## Community Resources – current services and recommendations:

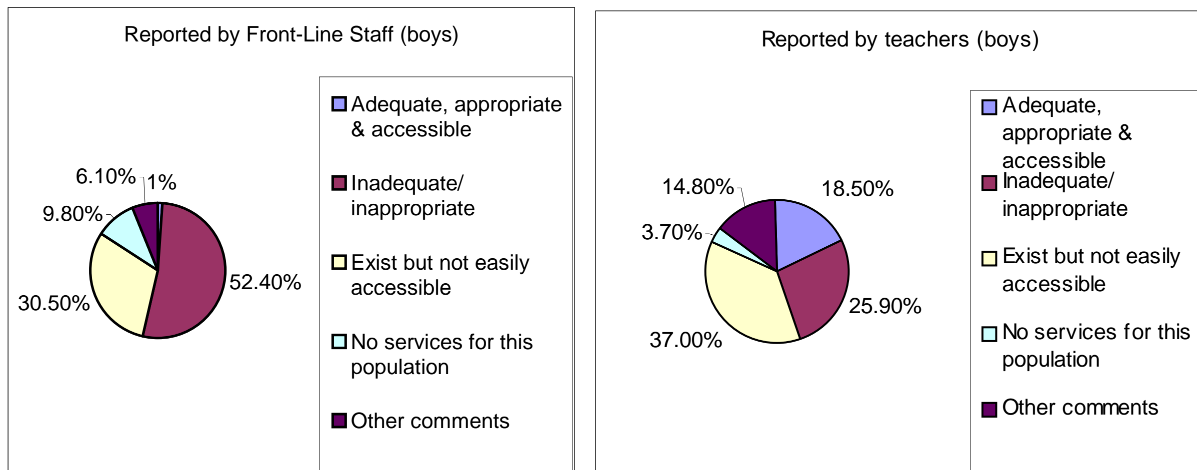
Respondents were asked to rate their perception of community resources in terms of being adequate, appropriate and accessible. They were also asked to identify services with which they are familiar, that provide service to children with sexual behaviour problems. Finally, respondents were asked to provide recommendations for meeting the needs of children with sexual behaviour problems. The results are discussed below.

### Are the current services in the community adequate?

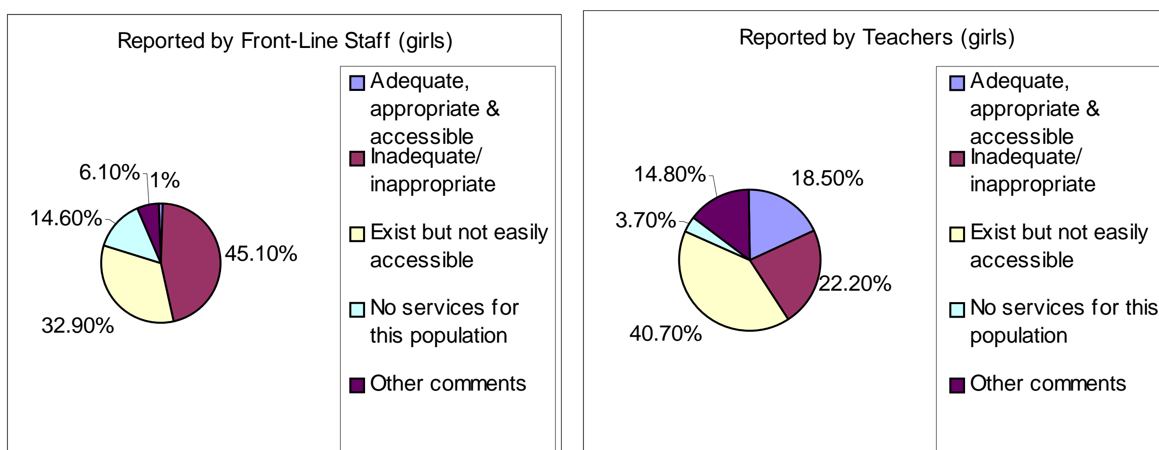
Respondents were asked for feedback on available community resources for this population of children. Respondents were asked to respond based on the adequacy, appropriateness and accessibility of services available for these children. Overall, results show that respondents perceive there to be a serious lack of appropriate and available resources for both boys and girls who act out sexually. A minority of front-line and educational professionals rated services as adequate, appropriate, and accessible.

Figure 3: Community resources

For Boys:




For Girls:



## Community perceptions of Available Services

Table 9 illustrates the community-based services that respondents indicated as being generally available to this population. Responses ranged from specialized intervention to educational materials to general services (such as family doctors). Although respondents were very inclusive in their identified services, many of the identified services either do not target sexualized behaviour problems, or do not serve children under 12. The research subcommittee of the London-Middlesex Child Abuse Prevention Council has separated the responses into categories to indicate the extent to which the services suggested by respondent are: 1) known to offer specialized services to children with sexual behaviour problems; 2) know to *not* offer specialized services to children with sexual behaviour problems; 3) general disciplines; and 4) other resources (not specific to children with sexual behaviour problems).

Table 9: Services Identified by Survey Respondents

| I. Services Known to Offer Specialized Services to Children under 12 with Sexual Behaviour Problems |
|---|
| ✓ Children's Aid Society (sexual abuse intervention program, Resource Consultant, perpetrator treatment, counselling, specialized therapy)<br>✓ London Health Sciences Centre, Child and Adolescent Program<br>✓ Clarke Institute **(in Toronto)** |
| II. Services Known to *Not* Offer Specialized Services to Children under 12 with Sexual Behaviour Problems |
| ✓ Wallenburg (private art and play therapy)<br>✓ All Kids Belong (Merrymount)<br>✓ Early Years Program (Madame Vanier Children's Services)<br>✓ CPRI<br>✓ Centre for Children and Families in the Justice System of the London Family Court Clinic<br>✓ Health Unit<br>✓ Sexual Assault Centre<br>✓ Family Services London<br>✓ Merrymount Children's Centre<br>✓ Centre for Studies of Children at Risk (research centre)<br>✓ Craigwood |
| III. General Recommendations Regarding Clinical Disciplines / approaches |
| ✓ Art therapy<br>✓ Play therapy<br>✓ Individual counselling<br>✓ Group counselling<br>✓ Family doctors<br>✓ School social worker<br>✓ Psychiatric hospitals<br>✓ Family therapists<br>✓ Private therapists<br>✓ Mental health agencies<br>✓ Child Psychologists |
| IV. Other Resources (Not specific to children with sexual behaviour problems) |
| ✓ Books on Sexual Behaviour Problems with children |

### Respondents Recommendations

Many respondents made suggestions about ways in which services could be enhanced. Again, the research subcommittee assisted in categorizing the range of recommendations for organization purposes. Table 10 provides an overview of service recommendations offered by survey respondents.

Table 10: Respondent Recommendations for Service Enhancement

| I. Recommendations Regarding Services for Individual Children |
|---|
| ✓ More individual counselling and treatment<br>✓ Long-term and intensive treatment programs<br>✓ Utilizing William Friedrich's treatment protocol<br>✓ Early identification<br>✓ Treatments that are specialized for sexual acting out behaviours<br>✓ Mirror services like the Sexual Assault Centre's adult services (** Sexual Assault Centre provides services to victims, not identified perpetrators)*<br>✓ Therapy on an outpatient basis or in secure residential facilities<br>✓ Specific and focused treatments (Cognitive Behavioural Therapy, behavioural, family systems)<br>✓ Psychiatric counselling |
| II. Recommendations Regarding Families |
| ✓ Support for families<br>✓ Removing the child from the home situation to keep the child safe<br>✓ Focus on family interventions |
| III. Crisis Services |
| ✓ Telephone crisis service (24-7 access)<br>✓ Kids Help Phone services<br>✓ Mobile street services |
| IV. Prevention Focused Recommendations |
| ✓ More preventative programs<br>✓ Better education and educational materials in schools (re: Sex Education, social and emotional education)<br>✓ Psycho-educational groups and preventative programs |
| V. System recommendations |
| ✓ Better education for front-line staff<br>✓ More training for teachers and daycare staff<br>✓ Quicker response / no waiting lists<br>✓ More accessible play therapy, art therapy, and counselling by specialized therapists<br>✓ Coordinate group treatment programs throughout the community agencies<br>✓ Public acknowledgment of the issue<br>✓ More funding needed to support existing services<br>✓ More funding to pay for specialized treatments<br>✓ Enforcement to ensure that treatments / therapy is followed through<br>✓ |

## What do professionals in this community want?

There was an overwhelming response from respondents about the need for professional training with 85-95% of respondents asking for the availability of more training options. In comparison, only 2% of front-line professionals and 4% of teachers indicated that they felt adequately trained to respond to the sexual behaviour problems that they encounter in children.

## Summary of Findings for Study 2 – Survey

Findings for this part of the project were based on the responses of 110 community professionals who responded to surveys. Eighty two of these professionals were front-line staff working in child protection and children's mental health centres and 28 professionals work in an educational capacity with children under the age of 12 years.

Professionals' perceptions of the 5 most concerning sexual behaviours among children showed no significant gender difference on rating behaviours for boys or girls. The behaviours that were rated most concerning involved oral-genital contact, inserting objects into their own/ another person's vagina/anus, engaging animals in sexual activity, and using force or coercion to elicit participation.

Respondents were asked what they believed may be contributing to the sexualized behaviours in children aged 12 years and younger. There responses were consistent with the research and clinical literature and indicated a wide range of factors, including: abuse, exposure to inappropriate media and adult sexual activity, peer-pressure, family dysfunction, psychological issues, poor role models, domestic violence, the increase in sexuality portrayed in the TV and/or media, and a 'sexualized society.'

When asked about implication for these children if they are not provided with adequate services, respondents indicated a rather poor prognosis. Respondent's perceptions about the long-term implications for boys and girls were for the most part similar with a very slight tendency to view boys as a greater risk to become perpetrators, sexual offenders, and violent individuals. Girls were more likely to be deemed at risk for future violence and victimization, vulnerability, unwanted pregnancies, psychological problems, and prostitution. However, overall the gender-based differences were not very significant. This lack of gender-based differences could be due to the face-validity of the survey and questionnaire and it is possible that respondents did not want to indicate that they viewed or treated boys and girls differently. It is possible that given a larger sample and a survey design that asked respondents about boys or girls (but not both on the same survey), responses might have shown greater variability on gender based differences.

Respondents were also invited to share their understanding of the community's resources for treatment and services available to these children. Most respondents indicated that services for this population were either inadequate/ inappropriate or if they existed they were not easily accessible. Recommendations were made for more individual and group counselling particularly treatment and counselling specifically for sexualized children not just those children who were also sexually abused. Recommendations also included education, safety planning, and access to 24-hour telephone crisis services, CAS and police intervention when required and the ability to ensure that treatment is followed up even if it requires enforcement or intervention. There was an overwhelming response from respondents about professional training with 80-95% of respondents asking for the availability of more training options.

# Discussion

Based on the collective data gathered in both phases of this research project, there are five main messages that emerge.

First and foremost, there is **widespread concern about children who exhibit sexual behaviour** problems in London and Middlesex County. Respondents to the surveys indicate a high level of concern for a wide range of sexualized behaviours, indicate an increasing trend in the numbers of children who have these behaviour problems, and feel ill-prepared to deal with these behaviours in their day-to-day practice. The file reviews suggested that this concern is not misplaced. Children with sexual behaviour problems were found to exhibit a range of other difficulties.

Second, this concern is not the result of being misinformed about the issues associated with sexual behaviour. In general, respondents indicated a **good awareness of the dynamics associated with sexual behaviour problems** in children. They identified a wide range of predisposing factors, which coincided with the results of the file review. Furthermore, these factors mirror those identified in the clinical and research literature.

Third, although there was evidence of general awareness of the predisposing factors of sexual acting out, there was also **evidence of social biases towards these children**. In particular, the prognosis identified in terms of the likelihood of these children becoming offenders or victims as adults suggests that service providers view these children very negatively. In addition, some of the labels used (e.g., molester, perpetrator) indicate that a small minority of front line professionals apply adult offender terminology to these children.

Fourth, respondents were almost unanimous in their identification of a **gap between these children's needs and available, appropriate and accessible specialized services**. The file reviews suggested that children may be sent to a wide range of generic services, likely in part because of a lack of specialized service or centralized referral source.

Finally, the variability in the data available in the file reviews indicates the **need for a standardized information recording form**. As the practice currently stands, it is unclear whether the absence of particular details means that certain behaviours were not assessed, or whether they were assessed and not present. Furthermore, the information is sometimes recorded in reference to an incident and sometimes in reference to the specific child, making it very difficult to ascertain baseline rates for any of the behaviours. A standardized protocol across agencies would facilitate better information gathering about children with sexual behaviour problems.

In conclusion, while this study has enriched our understanding of this problem in London and Middlesex community through rich descriptive and qualitative data, it has also highlighted the need for more research in this area, the lack of specialized and accessible services for this population and the need for more professional training. The greatest implication of this study is probably the realization of how little we know and understand about the complexities of children's sexual behaviours, the problems it causes for them and the complex life experiences that have influenced or contributed to these children's behaviours.

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*Appendix A*

**Characteristics of Sexual Behaviour Problems in Children**

Johnson (1998) has identified 20 characteristics of child sexual behaviours that raise concerns because they are not healthy or developmentally normal for children. Sexual behaviours in children may be considered problematic when:

1. The children involved in the sexualized play behaviours do not have a mutual ongoing play relationship. In other words, when play between the children involved is devoid of any other play behaviours and is limited to sexual behaviours.
2. The children engaging in the sexual behaviours are of different ages or developmental levels. Generally a difference of five years between the children puts them at distinctly different developmental levels, however depending on the children involved a difference of three years may also be significantly developmentally different.
3. Sexual behaviours are not balanced with other interests in the child's life and the child's demonstrates a preoccupation with sex or sexuality.
4. Children who seem to have too much knowledge about sexuality (beyond their developmental level), and behave in ways that are more consistent with adult sexual expression.
5. Sexual behaviours are significantly different than those of other same-age children.
6. Sexual behaviours that continue in spite of consistent and clear requests to stop.
7. Children who are unable to stop themselves from engaging in sexual activities. Sexual behaviour that is driven by anxiety, guilt or fear and is used as a way to cope with overwhelming feelings, often does not respond to normal limit setting.
8. Sexual behaviours that are eliciting complaints from other children and/or adversely affecting other children.
9. Children's sexual behaviours directed at adults who are uncomfortable receiving the overt (and often inappropriate) sexual gestures.
10. Children who do not understand their rights or the rights of others in relation to sexual contact.
11. Sexual behaviours that progress in frequency, intensity or intrusiveness over time.
12. When fear, anxiety, deep shame or intense guilt is associated with the sexual behaviours.
13. When children turn to other children and use adult-type sexual behaviours as sources of emotional warmth or to cope with loneliness.
14. Children who manually stimulate or have oral or genital contact with animals.
15. Children sexualize non-sexual things, interactions or relationships.
16. Sexual behaviours that cause physical or emotional pain or discomfort to self or others.
17. Children who use sex to hurt others. Children, who have experienced negative emotions or experiences paired with sexuality, see sex as a weapon to hurt or get back at people.
18. When verbal and/or physical expressions of anger precede, follow or accompany the sexual behaviours.
19. Children who use distorted logic to justify their sexual actions. For example, "they didn't say 'no'".
20. When coercion, force, bribery, manipulation or threats are associated with sexual behaviours.

*Appendix B*

## Data Collection Tool

***Case Data Sheet – Index Child.***

Our Case number: ___ ___ ___
Date of Birth (yy/mm/dd): _____ / ____ / ____
Gender: M / F

Initial Agency: _________________________________
Date of Agency Involvement: _____________________

Subsequent Agencies: 1. ___________________
2. ___________________
3. ___________________
4. ___________________
5. ___________________

Index Child History

Sexual Abuse Victim: Y / N. If yes, by whom? (Specify relationship to victim)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Physical Abuse Victim: Y / N. If yes, by whom? (Specify relationship to victim)

1. _______________________________
2. _______________________________
3. _______________________________
4. _______________________________
5. _______________________________

Neglected child: Y / N. If yes, by whom? (Specify relationship to victim)

1. _______________________________
2. _______________________________
3. _______________________________
4. _______________________________
5. _______________________________

*Appendix B (continued) – Data Collection Tool*
***Episode Sheet***

Our case number (Index Child): ___ ___ ___
Date of Episode (yy/mm/dd): _____ / ____ / ____

Date of Birth of Target Child (yy/mm/dd): _____ / ____ / _____
Gender of Target Child: M / F
Target child was living with (at the time of the incident): _________________________
Index Child was living with (at the time of the incident): _________________________
Relationship between the index child and the targeted child: ______________________

Specific Sexual behaviours: (refer to Sexual behaviour checklist for codes)

1. __________________________
2. __________________________
3. __________________________
4. __________________________
5. __________________________

Were adults present to witness the incident? Y / N
Circumstances of the event:
_________________________________________________________________________________
_________________________________________________________________________________
____________________________________________________________

Was force or coercion used? Y / N
Location of event: (refer to data collection sheet for codes) ___ ___
___ ___
___ ___

** Note: A separate Episode Sheet is required to document each incident of sexualized behaviour.*

*Appendix B (continued) – Data Collection Tool*
***Service Disposition/ Outcome***

01. Were services offered to the index child for Sexual Behaviour Problems? Y/N
02. Were services offered to the targeted child for Sexual Behaviour Problems? Y/N
03. Were services offered to the index child for Non-Sexual Behaviour Problems? Y/N
04. Were services offered to the targeted child for Non- Sexual Behaviour problems? Y/N
05. Were the services that were offered to the index child to address his/her Sexual behaviour problems carried out? Y/N. If yes, include date(s) ____________________.
06. Were the services that were offered to the targeted child to address sexual behaviours carried out? Y/N. If yes, include date(s) ___________________.
07. Were the services that were offered to the index child to address his/her Non-Sexual behaviour problems carried out? Y/N. If yes, include date(s) ____________________.
08. Were the services that were offered to the targeted child to address non-sexual problems carried out? Y/N. If yes, include date(s) ____________________.
09. No response / No services offered from the agency for Sexual Behaviour Problems
10. No response / No services offered from the agency for Non-Sexual Behaviour Problems
11. Was the index child referred to a children's mental health centre? Y/N. If yes specify date and referred centre ____________________________________.
12. Was the targeted child referred to a children's mental health centre? Y/N. If yes, specify date and referred centre _______________________________.
13. Was treatment offered to the index child for sexual behaviour problems? Y/N
14. Was treatment offered to the targeted child to address sexual behaviours? Y/N
15. Was treatment offered to the index child for Non-sexual behaviour problems? Y/N
16. Was treatment offered to the targeted child for Non-sexual behaviour problems? Y/N
17. Did the parents of the index child follow through with treatment for Sexual behaviour problems? Y/N
18. Did the parents of the index child decline treatment for Sexual behaviour problems? Y/N
19. Did the parents of the index child follow through with treatment for Non-sexual behaviour problems? Y/N
20. Did the parents of the index child decline treatment for Non-sexual behaviour problems? Y/N
21. Did the parents of the targeted child follow through with treatment addressing Sexual behaviours? Y/N
22. Did the parents of the targeted child decline treatment to address Sexual behaviours? Y/N
23. Did the parents of the targeted child follow through with treatment for Non-sexual behaviour problems? Y/N
24. Did the parents of the targeted child decline treatment for Non-sexual behaviour problems? Y/N
25. Outcome of treatment / services in not known

26. Parents /caregiver of the index child was advised to supervise their child's interaction with other children.
27. Parents of the index child provided with educational materials.
28. Parents of the targeted child provided with educational materials.
29. Home safety plan developed for the index child.
30. Home safety plan developed for the targeted child.
31. The index child was removed from caregiver's care after the sexual behaviour problem was identified.
32. Was the incident reported to CAS? Y/N

Other outcome (specify): ____________________________________

*Appendix C*

# Data Coding Package

**Part 1. Descriptive Data:**

- Age of the "index child" (i.e.: child who is engaging in age-inappropriate sexualized behaviours.). *(As Date of Birth)*
- Sex of the index child. [Male = 1; Female = 2]
- Age of targeted child/ individual. *(As date of birth)*
- Sex of targeted child/ individual. [Male = 1; Female = 2]
- Family composition of the index child. Child is living with (codes in table):*

| | |
|---|---|
| 01. Both biological parents | 19. Maternal uncle |
| 02. Single parent (biological mother) | 20. Paternal grandparents |
| 03. Single parent (biological father) | 21. Paternal grandmother |
| 04. Both adoptive parents | 22. Paternal grandfather |
| 05. Single parent (adoptive mother) | 23. Paternal aunt |
| 06. Single parent (adoptive father) | 24. Paternal uncle |
| 07. Biological mother + step father | 25. Other Relative (specify) |
| 08. Biological father + step mother | 26. Both foster parents - CAS |
| 09. Adoptive mother + step father | 27. Single parent foster mother - CAS |
| 10. Adoptive father + step mother | 28. Single parent foster father - CAS |
| 11. Biological mother + common-law partner | 29. Both foster parents - OPI |
| 12. Biological father + common-law partner | 30. Single parent foster mother - OPI |
| 13. Adoptive mother + common-law partner | 31. Single parent foster father – OPI |
| 14. Adoptive father + common-law partner | 32. CAS Group Home |
| 15. Maternal grandparents | 33. OPI Group Home |
| 16. Maternal grandmother | 34. Residential Treatment Home |
| 17. Maternal grandfather | 35. Biological relative of foster parents |
| 18. Maternal aunt | |

- Family composition of the targeted child/ individual. Child lives with:*
  *Same codes as above*
- Nature of sexualized behaviour incident. (Refer to Sexual Behaviour Checklist)*
- Were adults present to witness the incident behaviour? Y / N*
- Was force or coercion used? Y / N*
- Circumstances around the incident behaviour. (E.g.: during babysitting, sleepovers at friends' homes, visitation with non-custodial parent/ relative etc.)*
- Location of incident behaviour:*

| | |
|---|---|
| 01. Shared bedroom | 08. Family Bathroom |
| 02. Common living quarters in house. | 09. Public Bathroom |
| 03. Classroom | 10. Community recreation facility |
| 04. Schoolyard | 11. Other buildings on family property |
| 05. School Bus | 12. Buildings other than those on family property |
| 06. Public Transportation | 13. Playgrounds |
| 07. School Bathroom | 14. Other (specify) |

- Sexual victimization history of the index child. Was the index child victimized? Y / N. If Yes, Victimizer(s) was/ is:

| | |
|---|---|
| 01. Biological mother | 25. Step-brother |
| 02. Biological father | 26. Step-sister |
| 03. Adoptive mother | 27. Half-brother |
| 04. Adoptive father | 28. Half-sister |
| 05. Foster mother | 29. Foster brother |
| 06. Foster father | 30. Foster sister |
| 07. Maternal grandmother | 31. Classmate |
| 08. Maternal grandfather | 32. School acquaintance |
| 09. Maternal aunt | 33. Teacher |
| 10. Maternal uncle | 34. Daycare staff |
| 11. Paternal grandmother | 35. Group home staff |
| 12. Paternal grandfather | 36. Group home fellow resident |
| 13. Paternal aunt | 37. Treatment home staff |
| 14. Paternal uncle | 38. Treatment home fellow resident |
| 15. Male cousin | 39. Religious leader |
| 16. Female cousin | 40. Adult recreational staff/ leader |
| 17. Step-mother | 41. Adolescent recreational staff/ leader |
| 18. Step-father | 42. Adult family friend |
| 19. Mother's common-law partner | 43. Child / Adolescent family friend |
| 20. Father's common-law partner | 44. Nieces |
| 21. Male babysitter | 45. Nephews |
| 22. Female babysitter | 46. Other professionals |
| 23. Biological brother | 47. Other (specify) |
| 24. Biological sister | |

- Date of first sexualized behaviour incident.
- Dates of subsequent sexualized behaviour incidents.
- Relationship between index child and targeted child is:*

| | |
|---|---|
| 01. Biological whole sibling | 08. Nephew – aunt |
| 02. Biological half sibling | 09. Nephew – uncle |
| 03. Step- siblings | 10. Classmates |
| 04. Foster siblings | 11. Fellow daycare students |
| 05. Cousins | 12. Fellow group home members |
| 06. Niece – aunt | 13. Fellow treatment home members |
| 07. Niece – uncle | 14. Other (specify) |

*Appendix C (continued) – Data Coding Package*

**Part 2. Checklist of Behaviours.**

Category 1: Gender Identity

01 Dresses like the opposite sex
02 Talks about wanting to be the opposite sex.
03 Pretends to be the opposite sex when playing

Category 2: Sexualized Language

04 Uses words that describe sex acts.
05 Makes sexual sounds (sighing, moaning, heavy breathing, etc.)
06 Talks about sexual acts.

Category 3: Self–stimulation

07 Touches own private parts when in public places.
08 Masturbates with hand.
09 Masturbates with object.
10 Touches own private parts when at home.
11 Rubs body against people or furniture.

Category 4: Heightened Sexual Interest

12 Imitates the act of sexual intercourse.
13 Asks others to engage in sexual acts with him or her (including communication over the phone, written notes, drawings etc.)
14 Tries to look at people when they are nude or undressing.
15 Imitates sexual behaviour with dolls or stuffed animals.
16 Tries to view pictures of nude or partially dressed people (may include catalogues and printed material).
17 Talks about sexual acts.
18 Asks to view nude or sexually explicit TV shows (may include video movies or HBO-type shows)
19 Seems very interested in the opposite sex.
20 Asks or tries to view nude or sexually explicit material over the Internet.
21 Collects intimate apparel.

Category 5: Exhibitionism

22 Shows private parts to adults.
23 Undresses self in front of others.
24 Sits with crotch or underwear exposed.
25 Shows private parts to children.

Category 6: Non-penetrative touching

26 Touches other people's private parts.
27 Puts mouth on another child's or adult's sex parts.
28 Tries to undress other children or adults against their will (opening shirts, pants etc)
29 Touches animals sexually or tries to masturbate animals.

Category 7: Penetration

30 Inserts or tries to insert objects in his/her own vagina or anus.
31 Inserts or tries to insert objects into someone else's vagina or anus.
32 Inserts penis into someone else's mouth.
33 When kissing, tries to put tongue in other person's mouth.
34 Tries to penetrate an animal or tries to have the animal penetrate him/her.

Category 8: Other

35 Other sexual behaviours (please describe)

* Information to be gathered for each incident of sexualized behaviour.

**Part 3: Service Disposition**

33. Were services offered to the index child for Sexual Behaviour Problems? Y/N
34. Were services offered to the targeted child for Sexual Behaviour Problems? Y/N
35. Were services offered to the index child for Non-Sexual Behaviour Problems? Y/N
36. Were services offered to the targeted child for Non- Sexual Behaviour problems? Y/N
37. Were the services that were offered to the index child to address his/her Sexual behaviour problems carried out? Y/N. If yes, include date(s).
38. Were the services that were offered to the targeted child to address sexual behaviours carried out? Y/N. If yes, include date(s).
39. Were the services that were offered to the index child to address his/her Non-Sexual behaviour problems carried out? Y/N. If yes, include date(s).
40. Were the services that were offered to the targeted child to address non-sexual problems carried out? Y/N. If yes, include date(s)
41. No response / No services offered from the agency for Sexual Behaviour Problems
42. No response / No services offered from the agency for Non-Sexual Behaviour Problems
43. Was the index child referred to a children's mental health centre? Y/N. If yes specify date and referred centre.
44. Was the targeted child referred to a children's mental health centre? Y/N. If yes, specify date and referred centre.
45. Was treatment offered to the index child for sexual behaviour problems? Y/N
46. Was treatment offered to the targeted child to address sexual behaviours? Y/N
47. Was treatment offered to the index child for Non-sexual behaviour problems? Y/N
48. Was treatment offered to the targeted child for Non-sexual behaviour problems? Y/N
49. Did the parents of the index child follow through with treatment for Sexual behaviour problems? Y/N
50. Did the parents of the index child decline treatment for Sexual behaviour problems? Y/N
51. Did the parents of the index child follow through with treatment for Non-sexual behaviour problems? Y/N

52. Did the parents of the index child decline treatment for Non-sexual behaviour problems? Y/N
53. Did the parents of the targeted child follow through with treatment addressing Sexual behaviours? Y/N
54. Did the parents of the targeted child decline treatment to address Sexual behaviours? Y/N
55. Did the parents of the targeted child follow through with treatment for Non-sexual behaviour problems? Y/N
56. Did the parents of the targeted child decline treatment for Non-sexual behaviour problems? Y/N
57. Outcome of treatment / services in not known
58. Parents /caregiver of the index child was advised to supervise their child's interaction with other children.
59. Parents of the index child provided with educational materials.
60. Parents of the targeted child provided with educational materials.
61. Home safety plan developed for the index child.
62. Home safety plan developed for the targeted child.
63. The index child was removed from caregiver's care after the sexual behaviour problem was identified.
64. Was the incident reported to CAS? Y/N
65. Other outcome (specify)

**Other Codes:**

Gender:
01 Male
02 Female

Yes / No:
01 Yes
02 No
99 Missing data / incomplete information

Agency Codes:
01 Children's Aid Society London & Middlesex
02 Madame Vanier Children's Services
03 Child & adolescent Centre LHSC
04 Children's Hospital of Western Ontario – Inpatient Unit
05 CPRI
06 Merrymount
07 Private Counsellor
08 Family Physician
09 School staff
10 Other (specify)

* Indicates that data must be collected for each incident of sexualized behaviour.

*Appendix D*

**Sexual Behaviours Reported in File Reviews (Study 1- Results)**

1. Tries to look at others when they are nude or undressing – indicated in 5 cases.
2. Puts mouth on another child/ adult's sex parts – indicated in 2 cases.
3. Tries to undress other children/ adults against their will – indicated in 4 cases.
4. Tries to insert objects into someone else's vagina/ anus – indicated in 2 cases.
5. Talks about sexual acts – indicated in 3 cases.
6. Rubs body against other people or furniture – indicated in 3 cases.
7. Touches other people's private parts – indicated in 6 cases.
8. Uses words that describe sex acts – indicated in 1 case.
9. Makes sexual sounds – indicated in 2 cases.
10. Tries to insert penis into someone else's mouth – indicated in 2 cases.
11. Touches own private parts when at home – indicated in 1 case.
12. Undresses self in front of others – indicated in 10 cases.
13. Watches nude/ sexually explicit TV shows – indicated in 2 cases.
14. Touches own private parts when in public – indicated in 2 cases.
15. Tries to insert objects into his/ her own vagina/ anus –indicated in 1 case.
16. Shows private parts to other children – indicated in 2 cases.
17. Imitates the act of sexual intercourse – indicated in 1 case.
18. Dances in an exotic/ adult manner – indicated in 2 cases.
19. Mutual sexual play/exploration – indicated in 3 cases.
20. Attempts to watch adults engaged in sexual activity – indicated in 2 cases.
21. Uses toys in a sexual manner – indicated in 2 cases.

*Appendix D (continued) - Sexual Behaviours Reported in File Reviews (Study 1- Results)*

22. Tries to insert penis into objects – indicated in 2 cases.
23. Sexualized drawings- indicated in 2 cases.
24. Masturbation in public or with others– indicated in 2 cases.
25. Asks other children to engage in sexual acts with him/her – indicated in 2 cases
26. Tries to go into bathroom stalls with other children- indicated in 2 cases.
27. Unusual toileting practices – indicated in 4 cases
28. Other sexual behaviours – indicated in 5 cases.

*Appendix E*

## QUESTIONNAIRE FOR TEACHERS AND OTHER SCHOOL STAFF

Study: Survey of the Trends and Prevalence of Children under 12 years with Sexual Behaviour Problems in London and Middlesex County

Age: 20-29 30-39 40-49 50-59 60+ Gender: Male Female
Formal Education: ____________________________
Occupation: _________________________________
Work Setting: School Day-care centre Child Protection Services
Hospital Children's Mental Health Centre Residential Treatment home
Other (specify) ____________________

***All questions on this survey pertain only to children ages 12 and younger.*** *Please try and answer as many questions as you can. We encourage you to add any comments you may have with regards to this population of children, the services available and suggestions for additional services and training.*

1. How many years have you been working with children (under 12 years)? _________________
2. Have you ever witnessed children engaging in inappropriate sexualized activity by themselves and/or with other children? *Yes* *No*

3. If yes, did the sexual activity take place in a private or public place?
   a. Private place
   b. Public place (please specify) ___________________

4. What percentage of children that you encounter in your profession exhibit sexualized behaviours?
   (% Boys)______________ (% Girls)_______________

5. What do you estimate is the prevalence of children with sexual behaviour problems in London and Middlesex County? (% Boys)______________ (% Girls)_______________

6. How do you perceive this problem in London and Middlesex County as compared to 10 years ago? Is it:
   a. An increasing problem (more children are acting out sexually than 10 years ago)
   b. It is roughly the same (no perceivable increase or decrease in the numbers of children who act out sexually).
   c. A decreasing problem (fewer children act out sexually now than 10 years ago)
   d. Don't know / No response.
   With regard to boys: a. b. c. d.
   With regard to girls: a. b. c. d.

7. If you witnessed a young child engaged in sexual play or behaving in a sexualized manner, how would you react/ address this concern? *(Please circle all responses that apply for each gender)*
   a. Ask/ tell the child to stop the behaviour
   b. Address the behaviour with the child and explain why it is inappropriate
   c. Address the behaviour with parents of the child/ children that are acting out sexually.
   d. Consult with school authorities about how to address this problem
   e. Report the concern to authorities
   f. Other (specify) ________________________________________________
   With regard to boys: a. b. c. d. e. f.
   With regard to girls: a. b. c. d. e. f.

8. If a child is engaged in inappropriate sexualized play with other children how would you rate your level of concern for the children's safety compared to if the child was engaging in the behaviour alone?
   a. Level of concern would be the same
   b. Level of concern would be greater than if the child was playing alone
   c. Level of concern would be less than if the child was playing alone
   If the child engaging in sexual play is a boy: a. b. c.
   If the child engaging in sexual play is a girl: a. b. c.

9. How do you view sexual activity in children younger than 12 years of age (most of the time)?
   a. It's probably natural and ok
   b. The idea makes me somewhat uncomfortable
   c. It's a problem of some concern (depends on nature of the behaviour)
   d. It's very concerning, I worry about the child's safety
   With regard to boys: a. b. c. d.
   With regard to girls: a. b. c. d.

10. What label or terminology would you use to describe a child, who is exhibiting concerning and problematic sexual behaviours, to another person or another professional?
    Boys:________________________________________________________________
    Girls:________________________________________________________________

11. Among children who display concerning and problematic sexualized behaviours, what do you think is/are the underlying cause(s) / predisposing factor(s) of these children's sexualized behaviours.
    Boys:________________________________________________________________
    Girls:________________________________________________________________

12. What services do you know of that are available to this population of children to address their sexual behaviour problems?
    Boys:________________________________________________________________
    Girls:________________________________________________________________

13. How prepared do you think the community is to deal with this problem and provide appropriate services to this population of children? *( please circle one response for each gender)*
    a. Services are adequate, appropriate and accessible
    b. Services are inadequate / inappropriate
    c. Services exist but are not easily accessible
    d. There are no services for this population of children
    e. Other comments
    ____________________________________________________________
    With regard to boys: a. b. c. d. e.
    With regard to girls: a. b. c. d. e.

14. What do you feel will be the implications if these children are not provided with adequate and appropriate services to address their sexual behaviours.
    Boys:____________________________________________________________
    Girls:____________________________________________________________

15. What services would you recommend?
    ____________________________________________________________

16. What is your opinion on professional training to address this problem?
    a. Would you like to see the availability of more training options
    b. Professionals are adequately trained to deal with this problem
    c. Not sure, not a concern for you.

*Appendix F*

## QUESTIONNAIRE FOR FRONT-LINE STAFF

Study: Survey of the Trends and Prevalence of Children under 12 years with Sexual Behaviour Problems in London and Middlesex County

Age: 20-29 30-39 40-49 50-59 60+ Gender: Male Female
Formal Education: ___________________________
Occupation: ________________________________
Work Setting: School Day-care centre Child Protection Services
Hospital Children's Mental Health Centre Residential Treatment home
Other (specify) ____________________

***All questions on this survey pertain only to children ages 12 and younger.*** *Please try and answer as many questions as you can. We encourage you to add any comments you may have with regards to this population of children, the services available and suggestions for additional services and training.*

1. What do you estimate is the prevalence of children with sexual behaviours problems in London and Middlesex County? (% Boys)_____________ (% Girls)_____________

2. What percentage of children that you encounter in your practice, do you estimate, exhibits sexualized behaviours? (% Boys)_____________ (% Girls)_____________

3. What label or terminology would you use to describe (to another professional) a child who is exhibiting concerning and problematic sexual behaviours?
Boys:____________________________________________________________________
Girls:______________________________________________________________

4. How do you perceive this problem in London and Middlesex County as compared to 10 years ago? Is it: *( please circle one response for each gender)*
   e. An increasing problem (more children are acting out sexually than 10 years ago)
   f. It is roughly the same (no perceivable increase or decrease in the numbers of children who act out sexually).
   g. A decreasing problem (less children act out sexually now than 10 years ago)
   h. Don't know / No response
   With regard to boys: a. b. c. d.
   With regard to girls: a. b. c. d.

5. How prepared do you think the community is to deal with this problem and provide appropriate services to this population of children? *( please circle one response for each gender)*
   f. Services are adequate, appropriate and accessible
   g. Services are inadequate / inappropriate
   h. Services exist but are not easily accessible
   i. There are no services for this population of children
   j. Other comments
   ____________________________________________________________
   With regard to boys: a. b. c. d. e.

With regard to girls: a. b. c. d. e.

6. In your opinion, what do you think is/are the underlying cause(s) / predisposing factor(s) of these children's sexualized behaviours.
   Boys:______________________________________________
   Girls:______________________________________________

7. What services do you know of that are available to this population of children to address their sexual behaviour problems
   Boys:______________________________________________
   Girls:______________________________________________

8. In your opinion, what do you feel will be the implications if these children are not provided with adequate and appropriate services.
   Boys:______________________________________________
   Girls:______________________________________________

9. What services would you recommend?
   ______________________________________________

10. What is your opinion on professional training to address this problem?
    d. Would you like to see the availability of more training options
    e. Professional are adequately trained to deal with this problem
    f. Not sure, not a concern for you.

*Appendix G*

**Perceptions Questionnaire (Version 1)**

*Using the following scale please rate the extent to which you would be concerned about each of the following behaviours. You are asked to rate the behaviours once for girls aged 1-6 years old and once for boys aged 1-6 years old. Please circle one number for each behaviour and gender group.*

| 1 | 2 | 3 | 4 | NS |
|---|---|---|---|---|
| **Not at all Concerning** | **Somewhat concerning** | **Moderately concerning** | **Extremely concerning** | **Not sure** |

| | | **GIRLS AGES 1-6** | **BOYS AGES 1-6** |
|---|---|---|---|
| 01. | Child dresses like the opposite sex | 1 2 3 4 NS | 1 2 3 4 NS |
| 02. | Child talks about wanting to be the opposite sex | 1 2 3 4 NS | 1 2 3 4 NS |
| 03. | Child talks about wanting to be the opposite sex when playing | 1 2 3 4 NS | 1 2 3 4 NS |
| 04. | Child uses words that describe sex acts | 1 2 3 4 NS | 1 2 3 4 NS |
| 05. | Child makes sexual sounds (sighing, moaning, heavy breathing etc) | 1 2 3 4 NS | 1 2 3 4 NS |
| 06. | Child talks about sexual acts. | 1 2 3 4 NS | 1 2 3 4 NS |
| 07. | Child touches own private parts when in public places | 1 2 3 4 NS | 1 2 3 4 NS |
| 08. | Child masturbates with hand | 1 2 3 4 NS | 1 2 3 4 NS |
| 09. | Child masturbates with object | 1 2 3 4 NS | 1 2 3 4 NS |
| 10. | Child touches own private parts when at home | 1 2 3 4 NS | 1 2 3 4 NS |
| 11. | Child rubs body against people or furniture | 1 2 3 4 NS | 1 2 3 4 NS |
| 12. | Child imitates the act of sexual intercourse | 1 2 3 4 NS | 1 2 3 4 NS |
| 13. | Child asks others to engage in sexual acts with him/her (including via phone, written notes, drawings, emails etc.) | 1 2 3 4 NS | 1 2 3 4 NS |
| 14. | Child tries to look at other people when they are nude/undressing | 1 2 3 4 NS | 1 2 3 4 NS |
| 15. | Child imitates sexual behaviour with dolls or stuffed animals | 1 2 3 4 NS | 1 2 3 4 NS |
| 16. | Child tries to view pictures of nude/ partially dressed people (includes catalogues and printed material) | 1 2 3 4 NS | 1 2 3 4 NS |
| 17. | Child talks about performing sexual acts | 1 2 3 4 NS | 1 2 3 4 NS |
| 18. | Child asks to view sexually explicit TV shows and movies | 1 2 3 4 NS | 1 2 3 4 NS |
| 19. | Child seems very interested in the opposite sex | 1 2 3 4 NS | 1 2 3 4 NS |
| 20. | Child tries to view nude/sexually explicit material over the internet | 1 2 3 4 NS | 1 2 3 4 NS |

*Appendix G (continued) - Perceptions Questionnaire (Version 1)*

| | | | |
|---|---|---|---|
| 21. | Child collects intimate apparel (not their own) | 1 2 3 4 NS | 1 2 3 4 NS |
| 22. | Child shows private parts to adults | 1 2 3 4 NS | 1 2 3 4 NS |
| 23. | Child undresses self in front of others | 1 2 3 4 NS | 1 2 3 4 NS |
| 24. | Child sits with crotch or underwear exposed | 1 2 3 4 NS | 1 2 3 4 NS |
| 25. | Child shows private parts to children | 1 2 3 4 NS | 1 2 3 4 NS |
| 26. | Child touches other people's private parts | 1 2 3 4 NS | 1 2 3 4 NS |
| 27. | Child puts mouth on another child's or adult's sex parts | 1 2 3 4 NS | 1 2 3 4 NS |
| 28. | Child tries to undress other children or adults against their will | 1 2 3 4 NS | 1 2 3 4 NS |
| 29. | Child tries to insert objects into his/her own vagina or anus | 1 2 3 4 NS | 1 2 3 4 NS |
| 30. | Child tries to insert objects into someone else's vagina or anus | 1 2 3 4 NS | 1 2 3 4 NS |
| 31. | Child tries to insert penis into someone else's mouth | 1 2 3 4 NS | 1 2 3 4 NS |

| | | | |
|---|---|---|---|
| 32. | When kissing, child tries to put tongue into other person's mouth | 1 2 3 4 NS | 1 2 3 4 NS |
| 33. | Child tries to engage an animal in sexual acts | 1 2 3 4 NS | 1 2 3 4 NS |
| 34. | Children playing 'Doctor' | 1 2 3 4 NS | 1 2 3 4 NS |
| 35. | Restraining another child and demanding sexual contact | 1 2 3 4 NS | 1 2 3 4 NS |
| 36. | Refusing to share toys with other children | 1 2 3 4 NS | 1 2 3 4 NS |
| 37. | Punching another child in the face | 1 2 3 4 NS | 1 2 3 4 NS |
| 38. | Child's drawings depict sexual content and sexual interactions | 1 2 3 4 NS | 1 2 3 4 NS |
| 39. | Child's drawings depict sexually explicit drawings of genitalia | 1 2 3 4 NS | 1 2 3 4 NS |
| 40. | Other sexualized behaviours witnessed (please specify) | 1 2 3 4 NS | 1 2 3 4 NS |

______________________________________

*Thank you for your time and cooperation*

Appendix H

## Perceptions Questionnaire (Version 2)

*Using the following scale please rate the extent to which you would be concerned about each of the following behaviours. You are asked to rate the behaviours once for girls aged 7-12 years old and once for boys aged 7-12 years old. Please circle one number for each behaviour and gender group.*

| 1 | 2 | 3 | 4 | NS |
|---|---|---|---|---|
| **Not at all Concerning** | **Somewhat concerning** | **Moderately concerning** | **Extremely concerning** | **Not sure** |

| | | **GIRLS AGES 7-12** | **BOYS AGES 7-12** |
|---|---|---|---|
| 41. | Child dresses like the opposite sex | 1 2 3 4 NS | 1 2 3 4 NS |
| 42. | Child talks about wanting to be the opposite sex | 1 2 3 4 NS | 1 2 3 4 NS |
| 43. | Child talks about wanting to be the opposite sex when playing | 1 2 3 4 NS | 1 2 3 4 NS |
| 44. | Child uses words that describe sex acts | 1 2 3 4 NS | 1 2 3 4 NS |
| 45. | Child makes sexual sounds (sighing, moaning, heavy breathing etc) | 1 2 3 4 NS | 1 2 3 4 NS |
| 46. | Child talks about sexual acts. | 1 2 3 4 NS | 1 2 3 4 NS |
| 47. | Child touches own private parts when in public places | 1 2 3 4 NS | 1 2 3 4 NS |
| 48. | Child masturbates with hand | 1 2 3 4 NS | 1 2 3 4 NS |
| 49. | Child masturbates with object | 1 2 3 4 NS | 1 2 3 4 NS |
| 50. | Child touches own private parts when at home | 1 2 3 4 NS | 1 2 3 4 NS |
| 51. | Child rubs body against people or furniture | 1 2 3 4 NS | 1 2 3 4 NS |
| 52. | Child imitates the act of sexual intercourse | 1 2 3 4 NS | 1 2 3 4 NS |
| 53. | Child asks others to engage in sexual acts with him/her (including via phone, written notes, drawings, emails etc.) | 1 2 3 4 NS | 1 2 3 4 NS |
| 54. | Child tries to look at other people when they are nude/undressing | 1 2 3 4 NS | 1 2 3 4 NS |
| 55. | Child imitates sexual behaviour with dolls or stuffed animals | 1 2 3 4 NS | 1 2 3 4 NS |
| 56. | Child tries to view pictures of nude/ partially dressed people (includes catalogues and printed material) | 1 2 3 4 NS | 1 2 3 4 NS |
| 57. | Child talks about performing sexual acts | 1 2 3 4 NS | 1 2 3 4 NS |
| 58. | Child asks to view sexually explicit TV shows and movies | 1 2 3 4 NS | 1 2 3 4 NS |
| 59. | Child seems very interested in the opposite sex | 1 2 3 4 NS | 1 2 3 4 NS |
| 60. | Child tries to view nude/sexually explicit material over the internet | 1 2 3 4 NS | 1 2 3 4 NS |

*Appendix H (continued) - Perceptions Questionnaire (Version 2)*

| | | | |
|---|---|---|---|
| 61. | Child collects intimate apparel (not their own) | 1 2 3 4 NS | 1 2 3 4 NS |
| 62. | Child shows private parts to adults | 1 2 3 4 NS | 1 2 3 4 NS |
| 63. | Child undresses self in front of others | 1 2 3 4 NS | 1 2 3 4 NS |
| 64. | Child sits with crotch or underwear exposed | 1 2 3 4 NS | 1 2 3 4 NS |
| 65. | Child shows private parts to children | 1 2 3 4 NS | 1 2 3 4 NS |
| 66. | Child touches other people's private parts | 1 2 3 4 NS | 1 2 3 4 NS |
| 67. | Child puts mouth on another child's or adult's sex parts | 1 2 3 4 NS | 1 2 3 4 NS |
| 68. | Child tries to undress other children or adults against their will | 1 2 3 4 NS | 1 2 3 4 NS |
| 69. | Child tries to insert objects into his/her own vagina or anus | 1 2 3 4 NS | 1 2 3 4 NS |
| 70. | Child tries to insert objects into someone else's vagina or anus | 1 2 3 4 NS | 1 2 3 4 NS |

| | | | |
|---|---|---|---|
| 71. | Child tries to insert penis into someone else's mouth | 1 2 3 4 NS | 1 2 3 4 NS |
| 72. | When kissing, child tries to put tongue into other person's mouth | 1 2 3 4 NS | 1 2 3 4 NS |
| 73. | Child tries to engage an animal in sexual acts | 1 2 3 4 NS | 1 2 3 4 NS |
| 74. | Children playing 'Doctor' | 1 2 3 4 NS | 1 2 3 4 NS |
| 75. | Restraining another child and demanding sexual contact | 1 2 3 4 NS | 1 2 3 4 NS |
| 76. | Refusing to share toys with other children | 1 2 3 4 NS | 1 2 3 4 NS |
| 77. | Punching another child in the face | 1 2 3 4 NS | 1 2 3 4 NS |
| 78. | Child's drawings depict sexual content and sexual interactions | 1 2 3 4 NS | 1 2 3 4 NS |
| 79. | Child's drawings depict sexually explicit drawings of genitalia | 1 2 3 4 NS | 1 2 3 4 NS |
| 80. | Other sexualized behaviours witnessed (please specify) ______________________________ | 1 2 3 4 NS | 1 2 3 4 NS |

*Thank you for your time and cooperation*

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