



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

**Developed By:
The Institute for Human Services**

**Revised By:
The Institute for Human Services for the
Pennsylvania Child Welfare Training Program**

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July 1999

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

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Acknowledgements

The Pennsylvania Child Welfare Training Program thanks the members of the Quality Assurance Committee formulated to oversee and guide the revisions that were made to this curriculum:

- ◆ Julie Barley: Office of Children, Youth and Families
- ◆ Sally Cooper: Institute for Human Services, Columbus, OH
- ◆ Mary Lou Dubin: Northampton County Children and Youth
- ◆ Sally Fitch: Institute for Human Services, Columbus, OH
- ◆ Lisa Ford: Allegheny County Children and Youth
- ◆ Bob Gill: Reading Specialist
- ◆ Bob Gingrich: Lancaster Specialist
- ◆ Barb Hanna: Northwest Regional Training Center Director
- ◆ Melissa Haydt: Berks County Children and Youth
- ◆ Nicole Hewitt: PA Competency-Based Training & Certification Program

- ◆ April Hyatt: Somerset County Children and Youth
- ◆ Jean Landis: Private Consultant
- ◆ Jim Laughman: Lancaster County Children and Youth
- ◆ Deb Maggs: Lycoming County Children and Youth
- ◆ Peggy McCammon: Bedford County Children and Youth
- ◆ William McMillan: Philadelphia County Department of Human Services

- ◆ Jon Rubin: Bucks County Children and Youth
- ◆ Alicia Smith: Dauphin County Children and Youth
- ◆ Cathy Utz: Office of Children, Youth and Families
- ◆ Cindra Vallone: Erie County Children and Youth

The Pennsylvania Child Welfare Training Program is made possible by an Interagency Agreement between the Commonwealth of Pennsylvania, Department of Public Welfare, and Shippensburg University of the Pennsylvania State System of Higher Education.

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

Agenda for a Full-Day Curriculum on Sexuality of Children: Healthy Sexual Behaviors and Behaviors Which Cause Concern

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An Overview of the Curriculum

Rationale:

Child Welfare Professionals require the attitude, knowledge, and skills necessary to provide quality services to children and families. In making assessments regarding possible sexual abuse of children, the Child Welfare Professional must have a clear understanding about child sexuality, including healthy sexual behaviors as well as those, which cause concern. Additionally, Child Welfare Professionals must be able to assist parents and substitute caregivers in managing a child's sexually reactive behavior.

The following competency is taught in this curriculum:

The Child Welfare Professional can recognize age-appropriate sexual knowledge and awareness in children, and can identify abnormal and/or precocious sexual knowledge or preoccupation.

Learning Objectives:

Specific learning objectives are provided for each section throughout the curriculum. Comprehensive learning objectives for the curriculum include:

Participants will be able to:

Develop an awareness of a continuum of sexual behaviors for children.

Identify and discuss healthy sexual behaviors of children in various developmental stages.

Define what sexually reactive behavior is and learn management techniques that can be utilized with sexually reactive children.

Apply their knowledge of sexual play vs. problematic sexual behaviors to case examples.

Length of Workshop:

6 Hours

Materials:

Specific materials needed to conduct the training are listed for each section of the curriculum. Handout and overhead sections follow the curriculum.

Target Audience:

Child Welfare caseworkers who work with sexual abuse cases in any capacity.

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An Overview of the Curriculum (continued)

Expectations of Trainers:

The trainer of this curriculum should possess extensive knowledge and experience in the field of child sexual abuse. Specific knowledge of child development and the sexuality of children is critical. The trainer must understand the role of the Child Welfare Professional and the operation of the child welfare system in Pennsylvania.

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Section I: Introductions

Rationale:

Group trust and cohesiveness assist in creating a positive environment for learning. To this end, the trainer must establish his or her credibility, give an overview of the training, and begin to get participants to think about the topic at hand.

Learning Objectives:

Participants will:

Learn about the workshop and particular details of the training.
Introduce themselves to other participants and identify their training needs.

Time: 45 Minutes

Methods: Trainer presentation and group discussion

Materials Needed:

- **HO 1-1: Competencies and Learning Objectives**
- **HO 1-2: Training Agenda**
- **HO 1-3: Idea Catcher**
- **OH 1-1: Quote**
- **OH 1-2: Training Agenda**
- Flipchart

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Welcome: Introduction of Content and Leaders (10 minutes)

Trainer Note: Due to the sensitivity of this material, you will want to make sure that you establish your credibility as well as give enough time for participants to begin to feel comfortable with each other. Keep in mind, however, that this is only a one-day training with a lot of material to cover. Therefore, be watchful of the time and try not to exceed the 45 minutes allowed.

Leader(s) Welcome: Welcome the group and thank the host agency, the system, or any others that have helped make the training possible.

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

Provide participants with logistical information concerning restrooms, where they can smoke, local restaurants for lunch, the 15-minute rule and sign-in procedures.

Overview of Training: Introduce the workshop with the following lecturette material.
Overhead 1-1: Quote is available for use.

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

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

Historically, the American culture has denied the sexuality of children. Children have been deterred or re-directed from sexual exploration and discouraged from seeking sexual information. Sex education, if taught at all, contained only information regarding the process of reproduction with little or no mention of sexual behavior or responsibility.

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

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A. Group Introduction (35 minutes)

If the group is less than 25 participants, go around the room and have participants introduce themselves stating their name and the ages of children they have in their home, if they are caregivers. Have caseworkers talk about what they do and how long they have been with the agency.

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

Bridge: One way to get started is to do what we call a “Walk Around Activity”. Inform participants that around the room are several statements. For each statement, ask that they take a marker and put a check mark along the continuum, complete the sentence, or make a comment. Let them know they are allowed to pass, and all responses are anonymous.

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Trainer Note: Since this is such a sensitive topic for most professionals to discuss, a “**Walk Around Activity**” can allow the participants to anonymously address their own personal issues and thoughts regarding childhood sexuality. You should post 7-10 statements on very large paper and hang them on the wall prior to the start of the training. Some of the statements may include, but are not limited to:

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

For those comments stating an opinion, draw a continuum from Strongly Agree to Strongly Disagree and have participants mark their opinions.

Two of the statements should include WIIFM statements such as:

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

The trainer should write the statements on a large enough piece of paper so that the participants can either write their comments or stick their comments on blank index cards and tape. The trainer should make it very clear that this is an activity that the participants may selectively choose to respond to or they may choose not to participate at all. Allow approximately 15 minutes for the participants to walk around the room and respond to the activity

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

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

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

Distribute **Handout 1-1: Competencies and Learning Objectives**. Review this material with participants. Display **Overhead 1-2: Training Agenda** and distribute **Handout 1-2: Training Agenda** in order to review the major topics of the training curriculum. Answer any questions participants may have.

B. Idea Catchers

Distribute **Handout 1-3: Idea Catcher** and encourage participants to write down ideas they want to remember throughout the course of the day.

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

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Section II: Continuum of Sexual Behaviors

Rationale:

Sexuality has historically been a taboo subject area in the United States. Sexual behaviors can more easily be understood and distinguished when viewed through the lens of a continuum.

Learning Objectives:

Participants will:

- Learn about Johnson's continuum of sexual behaviors.
- Be able to identify characteristics of children they have worked with.

Time: 30 minutes

Methods: Trainer presentation

Materials:

- **HO 2-1: Johnson's Continuum**
- **HO 2-2: Characteristics of Child Sexual Behaviors: A Continuum**
- **OH 2-1: Johnson's Continuum**

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

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

Display **OH 2-1: Johnson's Continuum** and distribute **HO 2-1: Johnson's Continuum**. Discuss that this training will focus on the groupings of normal sexual behaviors and sexually reactive behaviors of the continuum. A description of mutual sexual behavior and child perpetrators will briefly be discussed. Other trainings discuss these two points in more detail.

Trainer Note: You may want to have a flipchart prepared that highlights the major points in the Four Areas outlined in Handout 2-2 (Characteristics of Child Sexual Behavior). This will allow participants to not have to read the entire handout at this time.

Distribute **Handout 2-2: Characteristics of Child Sexual Behavior: A Continuum**. For each section of the Johnson's continuum, highlight points from the Handout 2-2 and give a case example. If unable to come up with your own, case examples are outlined in the book by Gil and Johnson.

Trainer Note: If time allows, this is a great opportunity for participants to begin drawing on their own experiences. For each statement on the continuum, have participants share a case example, reminding them to use only first names and no identifying information.

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Section III: Healthy Sexual Behaviors of Children

Rationale:

Humans are born as sexual beings. From birth until death, sexual behaviors are exhibited. It is critical that child welfare professionals understand age-appropriate sexual development in children and teens.

Learning Objectives:

Participants will:

- Identify age-appropriate sexual development in children and teens.

Time: 90 minutes

Methods:

Trainer-led discussion
Small group work

Materials:

- **HO 3-1: Normal Child Sexual Development and Promoting Healthy Sexual Development**

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A. Overview

We do know that children are sexual beings. (Hopefully, the group came to some agreement on this statement during the “**Walk Around**” activity.) Sexual development appears to fall in line with the child’s physical, cognitive, social, moral and psychological development. Sexuality seems to change over time and is affected by and affects the child’s developmental perspective.

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

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

B. Developmental Stages

The developmental progression of a child’s sexuality can be traced. Trainer should distribute **HO 3-1: Normal Child Sexual Development and Promoting Healthy Sexual Development**, and trace the sexual development of children from birth to adolescence. It is important to remember that through each developmental stage every child is an individual and will progress through the stages at varying rates and with a slightly different slant than any other child.

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Trainer Note: Here are two possible ways to facilitate this content:

1. Trainers may want to develop flip charts that highlight the key points of each developmental stage so that the participants can refer to their handout, but not have to read the entire handout during the training session. In addition, it may be helpful for the participants to “**Mind Map**” the six developmental stages that will be discussed. A “**Mind Map**” is each participant’s “notes” to him/herself regarding the information that she/he would like to remember from the training. The participants are asked to write the words “Normal Child Sexuality” in the middle of a large piece of blank paper. The participants are then asked to draw six sections branching out from the middle picture. As each one of the six developmental stages are presented each participant is asked to draw a picture or series of pictures that will assist him/her to recall the concept being presented. Each participant’s “**Mind Map**” is private and should not be shared. The trainer should provide the participants with large blank paper, crayons and markers to complete their “**Mind Map**”.

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

0 – 2 6 – 9 13 – 18
3 – 5 10 – 12

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

- a) List some of the behaviors seen in this age group that reflect their sexual development.
- b) What are children this age thinking, doing, saying, that reflect their sexual development?
- c) Are there some “firsts” that happen in this age group that impact sexual development? (i.e., learning parts of the body, puberty)

As groups report out, highlight or add significant pieces for each developmental stage as found in the handout and following content

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Content:

- Pre-Birth:** The pre-birth period for a fetus is a period of constant change and growth. Over the course of the last 10-15 years there has been a considerable effort to research and analyze growth that takes place in the womb. Biologically, we know that all embryos are female at the time of conception. Somewhere between the sixth and twelfth week the fetus can be observed to develop a male sexual apparatus. At that time, the pathways are formed from the brain to the mouth, genitals and anus. At six months, the fetus has been observed to touch its mouth and genitalia. Involuntary penile erections have also been observed in the womb. The meaning assigned to these biological actions has not yet been determined. The topic of fetus sexuality is a highly controversial area that has not been totally validated. Although no conclusions can be drawn regarding the intent of fetus behavior at this time, it is safe to state that human behavior is purposeful and often, self-gratifying.
- 0 – 2:** Infants are born with neurological capacity to derive pleasure from their bodies. This includes the genital area. Infants can be observed several times a day engaged in a range of self-stimulating behaviors such as thumb sucking and breast-feeding. At this stage infants learn that touching feels good and that the physical expression of affection is a way to meet their basic needs. At 6-12 months infants can identify their primary caregivers and are able to link the mental image of the caregiver with the affection that they receive from the caregiver through the process of being fed and held. Infants learn to associate pleasurable sensations with the mouth and genital area. By the age of two, children have increased interest in touching their genitals; are intensely curious about sexual differences; and are voyeuristic and exhibitionists.
- 3 – 5:** Pre-school children (ages 3-5) are in a developmental stage of intense curiosity. Curiosity serves to educate the child about his/her world. Most child developmentalists believe that most of our learning takes place by the time that we reach age 5. Preschoolers are extremely interested in their own bodies at this time due to their heightened levels of exploration and emphasis on toilet training. Children are able to recognize the physical differences between boys and girls at approximately age 2 or 3. Caregivers of preschoolers may observe mutual sex play between children of this age which can involve taking advantage of opportunities to look at or touch another child's body. Children may also begin game playing (i.e., playing doctor) where they will show each other their body parts. Preschoolers also develop or repeat words or names for body parts and functions of their private areas. Sexual exploration between children is very typical. Since children may make no attempts to hide their curiosity, adults who encounter mutual sex play between children should handle the

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situation matter-of-factly. The children should not be reprimanded for their exploration, but should be re-directed in their actions.

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

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

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

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

The increased focus on male and female roles at this developmental level permits the child to identify with one sex or the other. At this point, children typically feel comfortable with their gender and attempt to align themselves with age mates of the same gender. For early school aged children there may be great competition between the boys and the girls. This may be evident by observing 5 or 6-year-old children playing on the school playground. The boys typically play with the boys on one end of the playground and the girls play with the girls on the other end of the playground. As school aged children mature, these harshly drawn lines

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blend. At 9 to 10 years of age, children attempt to explore their interest in heterosexual or homosexual relationships. Masturbation continues as a primary sexual behavior but the child is more discrete.

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

Developmentally, pre-teens appreciate not only the mechanical aspects of sexuality, but also the emotional aspects of adult sexuality.

Preadolescents are cognitively able to solidify their values, cultural influences, and religious standing regarding the expression of their sexual feelings. They should have established “rules” regarding their sexual conduct and developed guidelines concerning their responsibility in a sexual relationship.

- 13 –18:** Adolescents (ages 13-18) are involved in a wide range of sexual behaviors, including kissing, foreplay, simulated intercourse and intercourse. Adolescents are still interested in viewing the bodies of others and still utilize sexual joking and language to express their sexuality. Research states that most adolescents in rural communities and small towns begin to have sexual intercourse between the ages of 16 and 18. In large towns and communities it is likely that the average age drops (Gil & Johnson). A study conducted by Flax (1992) revealed that more than half of all high school students in the ninth to twelfth grades had sex. Black students were more likely than Caucasian or Hispanic students to have had sex, and boys were more likely than girls to have done so. In addition, it is important to note that Kinsey’s research demonstrates that it is common for adolescents to engage in same sex experiences during this period of exploration. Same sex or opposite sex activities are a means for adolescents to establish their sense of self and try on a number of different roles. The utilization of fantasy and sexual materials may also be prevalent for this age group, especially for young males. The research on the role of pornography and the effects that it has on children and adolescents is highly controversial.

Emotionally, adolescents are able to conceptualize the physical expression of sexuality and the issues of intimacy. The adolescent is

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learning the implications of an emotional commitment in a romantic relationship and is able to take responsibility for his/her actions. Issues surrounding the topics of S.T.D.'s and birth control should be a part of the sexually active adolescent's world.

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

Note: It is not uncommon for an adult who works in a residential placement center to walk in on several children engaged in mutual masturbation. This situation should be handled by the adult in a matter-of-fact tone, while attempting to redirect the children's activities. Mutual masturbation can over-stimulate highly aroused children and create a potentially vulnerable position for other children or adolescents

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Section IV: Sexually Reactive Children

Rationale:

Child Welfare Professionals must understand the nature of sexually reactive behaviors in children and the signs that a behavior is sexually reactive. In order to aid parents and caretakers, workers must know management strategies for such behaviors.

Learning Objectives:

Participants will:

- Define the term “sexually reactive” and enhance participant’s ability to identify sexually reactive behavior
- Gain strategies for managing sexually reactive behaviors.

Time: 90 minutes

Methods:

Trainer-led discussion
Small group work

Materials:

- **OH 2-1: Johnson’s Continuum (used previously in Section II)**

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Trainer Note: Revisit **OH 2-1: Johnson's Continuum**, and report to the participants that this section of the continuum focuses on sexually reactive children.

A. Definition

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

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

1. Sexually abused children are trying to make "sense" of their victimization. The more the child attempts to make "sense" of the victimization, the more confused he/she becomes. Children classified as sexually reactive typically act out shortly following their own abuse or at a point when they feel safe (i.e., foster care).
2. Chronic exposure to explicit sexual materials revolves around the child having access to highly sexualized materials (i.e., children who view unlimited sexual materials or hard core pornography, or children who are encouraged to discuss sexualized thoughts.)
3. Sexually reactive children who come from families where the boundaries are too loose do not fully understand what is appropriate behavior. Children who come from "crack" homes where the "climate" of the home is too permissive are key examples of the grouping. Another example is a child whose parents engage in oral contact in the front seat while their child is reportedly "sleeping" in the back seat.

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

B. Behaviors

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Behaviors displayed by sexually reactive children can include “excessive masturbation”, overt sexual behaviors with adults and/or other children, insertion of objects into one’s genitals or other behaviors and talk intensely focused on sexuality.

C. Affect

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

D. Managing the Behavior

The sexual behaviors of sexually reactive children must be fully addressed. Children identified and assessed as sexually reactive should be confronted with their behaviors and re-directed to more appropriate behaviors. Since these children’s behaviors are not ingrained patterns of secrecy or manipulation, they can respond to limit setting and establishment of boundaries.

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

Activity: The trainer should ask participants to break into several small groups to present a case where the caseworker was confronted with a child who possibly could be assessed as Sexually Reactive. Each group should discuss one child in anonymous terms, using no identifying demographic information. The presentation of the child should last no longer than 5 minutes.

Trainer Note: Circulate to make sure groups are discussing sexually reactive vs. normal or offending behavior. You may want to have several prepared case studies for any group struggling to come up with one of their own.

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

Each small group will compile only one list on newsprint. Have them post it and report out. During the discussion, be sure to highlight the following information:

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

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

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

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

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

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

2. The parent needs to identify the problem and offer alternatives.

Label/React.....Monitor....Confront/Prohibit....Refer

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

“I see you touching Johnny’s penis.”

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

“It makes both me and Johnny uncomfortable.”

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

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

It is important to monitor continually not only to help in the re-education of this child but also to prevent any victimization of others. In some cases, the

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seriousness of the behavior prevents you from waiting for a second occurrence. Your response to the child may need to be within a few minutes.

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

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

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

5. Ignoring problematic behavior does not help the child recover. Close observation and monitoring are necessary to enable the child to learn about what precipitates their sexualized behavior and identify other ways to express those feelings.

E. Masturbation

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

However, masturbation is also listed as a behavior indicator of sexual abuse on many indicator lists. There is no legal definition of “excessive” masturbation and only recently has a clinical definition been offered. Sgroi defines “excessive” as, “when a child is older than 3, the child can do little else (compulsive), the activity occurs in public, the child avoids other childhood activities and the child persists in inserting objects in the rectum or vagina without regard to pain of self-injury.” Johnson describes “excessive”

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masturbation as, “when children don’t seem to have any control over their behavior, are focused on the activity to the exclusion of other activities, or have hurt themselves.”

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

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

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

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

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Section V: Application of Knowledge

Rationale:

Child Welfare Professionals need to understand and be able to distinguish between normal sexual exploration in children and potentially problematic behaviors that cause concern and need to be addressed.

Learning Objectives:

Participants will:

- Identify dynamics to be considered when evaluating behaviors as normal sexual exploration versus potentially problematic behaviors.
- Apply new knowledge.

Time: 60 minutes

Training Methods:

Trainer presentation
Small group exercise

Materials:

- **HO 5-1: Sexual Play vs. Problematic Sexual Behaviors Case Examples**
- **OH 5-1: Dynamics of Sexual Play vs. Problematic Sexual Behaviors**
- **Trainer's Guide to Small Group Activity:**
Dynamics of Sexual Play vs. Problematic Sexual Behaviors

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A. Dynamics (15 minutes)

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

Display **OH 5-1: Dynamics of Sexual Play vs. Problematic Sexual Behavior**, and discuss:

- **Age Difference** – Age difference between children is one factor that must be considered. Sex play between children who are peers and hold a 3-year or less age span is acceptable by most experts. This is lower than the 4-year span previously considered by the professional community. It should be noted that neither a 3 or 4 year age span is a legal or clinically validated number. **Note:** Some professionals working with youthful offenders have noted that some of these children are offending 3 to 5 years older than themselves.
- **Size Difference** – The size difference between children involved is another factor that must be considered. For example, one child may physically tower over another child or use his/her physical stature to threaten or dominate another child.
- **Difference in Status** – If one child is in a position of authority or placed in a position of power (i.e., babysitter, temporary caregiver) over another child, then she/he may be able to compromise another child's ability to make decisions. Intelligence and/or developmental level can also be a variable of status.
- **Type of Sexual Activity** – Historically, the professional community has always assessed a child's sexual behavior based solely on this criteria. For example, if a child engaged another child in observing his/her private areas we would have determined this to be sex play. If the child touched another child, however, we have viewed this as problematic sexual behavior. The type of sexual activity is an important piece in assessing the child's sexual behavior, but not the only one! Remember that sexual interest and activity may vary depending on the cultural, moral or religious values/beliefs of the family and child.
- **Other Factors to Consider Include:** (Groth & Laredo, Sgroi)
 - a. How the sexual contact takes place (on the playground)
 - b. How persistent it is (was re-direction attempted)

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

B. Application (45 minutes)

The trainer should distribute **HO 5-1: Sexual Play vs. Problematic Sexual Behaviors Case Examples**. The participants should return to their small group settings to discuss the 6 case examples presented. Each group should assess the case examples using the criteria presented above. The group should classify each scenario as healthy or problematic and discuss the characteristics that determine the classification. One group member should record the problem-solving process and one group member should be ready to report on the group's decisions. The trainer should reunite the large group and provide ample time for discussion surrounding the small group's discussion. The trainer should use the enclosed **Trainer's Guide** by Eliana Gil to emphasize the important characteristics of each case scenario. If time is short the trainer may choose to complete this activity by assigning each group only one or two of the case scenarios to discuss.

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Section VI: Conclusion

Rationale:

An important part of training is to assist in the transfer of learning to the work setting. This section is designed to assist participants to consider what they have learned and how they will apply it to the work setting.

Learning Objectives:

Participants will:

- Recognize new attitudes, knowledge and skills learned in the training

Time: 15 minutes

Methods:

Individual reflection and group sharing

Materials:

- **Handout 6-1: Bibliography**

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A. Summary

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

Ask participants to look over notes and review newsprints posted on the walls and think about what they learned today that was especially helpful. Suggest that they take a few minutes to write down or highlight any new awareness or ideas they gained during the training on their **Idea Catcher (Handout 1-1)**.

Distribute **Handout 6-1: Bibliography**, which provides resources that participants can obtain if desired.

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

B. Evaluation

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