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ABSTRACT

This practicum was designed to improve Child Protective Services in a western state to sexually reactive children under the age of 10 by targeting four areas of the service delivery system: screening, assessment, treatment, and foster care. A panel of agency staff from all service areas researched, designed, proposed, and implemented changes throughout the agency that affect sexually reactive children. Products of this practicum include a Screening Assessment, criteria for confirming a young perpetrator, a Treatment Options List, a curriculum outline for training foster parents, and the "Sexually Reactive Children and Child Protection Manual." The Risk Assessment and the criteria for identifying a young perpetrator have been adopted for state-wide use to standardize social casework practices across counties. The agency family therapist is developing a treatment group for low income sexually active children. The manual has been distributed throughout the state. Appendixes include: Preliminary Coursework Survey; standardized screening evaluation; risk assessment evaluation; treatment options evaluation; foster parent program evaluation; resource survey; treatment options list and foster parent training outlines. (Author/NB)

Improving Child Protection Services To Children Under Ten Who Display Sexually Reactive Behaviors

by

Patricia A. Verstraete

Cluster 46

A Practicum II Report presented to the
Ed.D Program in Child and Youth Studies
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

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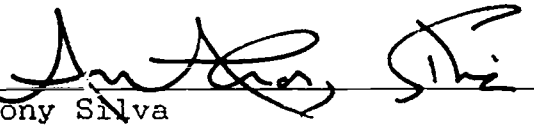
PRACTICUM APPROVAL SHEET

This practicum took place as described.

Verifier: 
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This practicum report was submitted by Patricia A. Verstraete under the direction of the advisor listed below. It was submitted to the Ed.D Program in Child and Youth Studies and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

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Date of Final Approval of Report

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This practicum is dedicated to the memory of Stanley Verstraete who found innocence and joy in all children.

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Child Protection/ Sexually Reactive Children/ Child Sexual Abuse/ Child Perpetrator/ Risk Assessment/ Caseworker Training/ Children At Risk/ Service Delivery System

This practicum was designed to improve Child Protective Services to sexually reactive children under the age of ten. Four areas of the service delivery system were targeted: screening, assessment, treatment and foster care.

A Panel consisting of agency staff from all service areas worked together to research, design, propose and implement changes throughout the agency that affect sexually reactive children. Products of this practicum include a Screening Assessment, criteria for confirming a young perpetrator, a Treatment Options List, a curriculum outline for training foster parents and the *Sexually Reactive Children and Child Protection Manual*.

The Risk Assessment and the criteria for identifying a young perpetrator have been adopted for state-wide use to standardize social casework practice across counties. The agency family therapist is developing a treatment group for low income sexually reactive children. A second training session for foster parents has been scheduled. One hundred copies of the manual have been distributed throughout the agency, the community and the state.

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CHAPTER I

INTRODUCTION

DESCRIPTION OF WORK SETTING AND COMMUNITY

The setting of this practicum is a Child Protection Unit of a county-administered Social Services Department in a western state. The Department is mandated to respond to all allegations of child abuse or neglect that occur within the county. The county's population is 93,145. The county is agriculturally based. Within this county there are one large city with a population of 32,000 and many smaller towns. Approximately 17,000 children under the age of twelve reside in this county.

The Department has three Units that respond to the problems of children and youth. These are the Child Protection Unit, the Adolescent Unit and the Resource Unit.

The Child Protection Unit provides services to children in elementary school or younger. The Adolescent Unit works with youth in middle school and high school. The Resource Unit licenses foster and adoptive homes and provides services to

children who are not likely to be reunited with their biological families.

Both the Child Protection and the Adolescent Units conduct abuse/neglect investigations, assess level of risk, confirm or rule out abuse allegations and provide protection to children through therapeutic, legal and educational interventions.

The Child Protection Unit is staffed by thirteen caseworkers, a case aide and an administrator. This Unit is divided into two teams, the investigation or intake team and the ongoing or treatment team. The investigation team responds to abuse allegations. The treatment team provides services to children who are mandated to receive services because they are named on a Dependency and Neglect petition. Families who seek services voluntarily or children who are high risk but have not been named in a petition are entitled to services according to the State's Children's Code. These services are currently being provided by the investigation team.

The American Civil Liberties Union has filed an intent to bring a class action suit on behalf of the state's children because the Department is not meeting mandates to protect children. The Department is funded at 54% of the recommended level. The Department has reorganized four times in the past three years to provide a higher level of services to children.

However, it appears that at the current level of funding it is impossible to provide adequate mandated services.

In 1992 Child Protection received 1729 allegations of child maltreatment. This included 539 allegations of physical abuse, 350 allegations of sexual abuse, and 840 allegations of neglect. Enough evidence was discovered in 20% of these cases to confirm abuse or neglect. Forty-seven confirmed cases were severe enough to warrant long term court intervention and were transferred to the treatment team. Treatment caseworkers report that most of the families who receive services from the treatment team will be involved with the court system for at least a two year period. This may appear to be a long time for a family to be involved in the Child Protection System. However, only children who have been adjudicated dependent and neglected, that is, proven in court by a preponderance of evidence to have been abused or neglected, receive this level of services.

About a third of the abuse/neglect allegations received are ruled out and the children are at low risk for abuse. No services are offered and these cases are closed within thirty days. Cases in which problems are identified but are not severe enough to warrant court intervention or in which the severity of the problem cannot be proven are the types of cases that are not receiving the level of services needed to protect children in this community.

Writer's Work Setting and Role

The writer has been an investigating caseworker with this Department for three years. When a case is assigned the worker reviews the allegations, coordinates the investigation with law enforcement and reviews family history if there have been prior abuse/neglect allegations.

The worker meets with the victim to determine the validity of the referral and to assess risk of future abuse and neglect. The investigating caseworker must assess risk to all children living in the household, not just the identified victim. Parents must be interviewed and in most cases a home visit should be made.

If the risk of future abuse is high or if abuse is confirmed the caseworker must offer a case plan to mitigate the problems that place the child at risk. Services vary according to family circumstances. If the parents appear to be unwilling or unable to comply with a voluntary treatment plan the caseworker may petition the court for protective orders.

Other functions of Child Protection caseworkers include answering the Child Protection hotline, providing 24 hour crisis interventions, conducting institutional abuse investigations, and serving on committees whose goals are to improve services to children.

CHAPTER II

STUDY OF THE PROBLEM

PROBLEM DESCRIPTION

An amendment to the 1991 Children's Code gave the responsibility and the authority to investigate all alleged reports of sexual abuse committed by children under ten to the County Departments of Social Services. This amendment did not provide guidelines for these investigations, nor did it provide training for investigators. This amendment did not address treatment issues or victim issues, nor did it provide funding for extra staff necessary to fulfill this obligation.

Gil (1987) defined child sexual abusers as "anyone who forces a young child to have sexual contact of any kind, when that child is either too young or unable to consent, or when a child is forced or tricked or bribed into having sexual contact" (p.6). Social casework practice and literature concur that very young children engage in sexually offending behaviors towards other children. The key elements in defining abusive behaviors are the use of force, either physical or

psychological, and the ability of both parties to consent to the sexual contact. There is still controversy among professionals about how to label sexually offending behaviors of very young children. Some chose to label these children young perpetrators because to define these behaviors in any other way may be seen as a minimization of the problem. Others suggest this terminology is too harsh and connotes a negativism that could present an obstacle to these children receiving humane care, education and services. For the purposes of this project children who engage in sexually offending behaviors were referred to as sexually reactive children.

Both social casework practice and current research indicate that there is a difference between normal child sexual play and sexually reactive behaviors. Victims of sexually reactive children may display the same negative reactions to these behaviors as victims of physical trauma or sexual abuse. Sexually reactive children and their families present with an array of problems and issues. Families who are motivated to make changes have expressed frustration with the lack of services in this community. Many times parents of sexually reactive children are not committed to making changes because they do not perceive that there is a problem.

In this state when children reach their tenth birthday they can be held accountable for criminal behaviors. Children

over ten who engage in sexually aggressive behavior toward a non-relative can receive help through the law enforcement and criminal justice systems. Their victims can receive help through the criminal justice system's Victim's Compensation Program. Intrafamilial sexual aggression by children over ten is addressed jointly by law enforcement and Child Protection Services.

The children under the age of ten who display sexually reactive behaviors are the children who are falling through the system's gaps. Most treatment programs will not accept young perpetrators into their programs unless there are court orders mandating treatment. Victims of prepubescent children may have a difficult time financing therapy. They are not entitled to Victim's Compensation because the behaviors of young perpetrators are not criminal as defined by state statutes. Therefore, those they injure are not considered victims of a crime. Some children who are displaying sexually reactive behaviors may not be receiving assessments because Child Protection screening criteria may not identify this referral as a high priority.

The problem is: In this community children under the age of ten who display sexually reactive behaviors receive inconsistent services.

Problem Documentation

Evidence that prepubescent children who display sexually reactive behaviors receive inconsistent services in this community was supported by an interview with Central Registry personnel, analysis of the writer's personal caseload, and a survey of Child Protection workers.

Central Registry is a data base that contains information about children who have been abused and their abusers. The State Department of Social Services expressed concern about this issue but could not offer clear guidelines as to when a sexually reactive child should be placed on the Central Registry as a child molester. Children as young as five have been placed on the Registry as offenders. The Registry at that time deferred to the judgement of the investigating caseworker. The State Department recognized that their inability to establish clear guidelines caused confusion at the county level. Because of the inconsistencies and ambiguities about child perpetrators, in the summer of 1993 a work group with representation from county departments of Social Services was formed to identify issues pertaining to placing young perpetrators on the Central Registry.

From January through August of 1992 this writer was asked to assess eleven children under the age of ten who were sexually aggressive with other children. Nineteen victims were identified. In all cases the writer documented that these

children needed extended services. However, in many cases the appropriate services were not available in the community. In four cases the parents refused to allow their children to participate in treatment. Three case scenarios are presented to help clarify some of the systemic issues of the sexually reactive child. Identifying information in these case studies has been altered to protect the confidentiality of these families.

> *case a:* June is an eight year old who was adopted at birth. Her adoptive parents divorced two years ago but are still disputing custody and child support. June's mother found June and a six year old naked. June was kissing this child's vaginal area. The six year old disclosed that earlier in the day June had tried to force a toy up the vagina of her four year old deaf sister. When the Child Protection investigator talked with June about these incidents June became hysterical. She flung herself on the floor and began rocking herself back and forth while sucking her thumb. June admitted to the allegations against her. She gave many verbal cues that someone was hurting her sexually, but she refused to give a disclosure.
>
> June was confirmed on the Central Registry. Her parents used June's behaviors to continue their fighting against each other. Both parents wanted to "handle the problem themselves." June received no therapy because both parents were professionals who were afraid this problem would effect their careers.
>
> *case b:* Rose is a nine year old who disclosed to her school counselor that she molested nine children including her brother who is three years younger than she. Rose's parents are divorced. Her father has remarried a woman 17 years younger than himself. Her mother married a man 22 years her senior. This family had extensive involvement with Child Protection as an intact family. The father is schizophrenic. The mother is chronically depressed. Rose alternates living with each parent. Rose

readily disclosed her inappropriate behaviors. She insisted that no one ever touched her or taught her how to do these things.

Within 24 hours after her disclosure Rose attempted suicide and was committed to a psychiatric hospital. She stayed in the hospital for thirty days. She has been in individual out-patient therapy for six months but has made little progress.

case c: Seven year old Rich was caught three times trying to insert his penis into his three year old sister's buttocks. Five months ago the mother called Child Protection because she found Rich and his eight year old sister naked in bed. At that time another caseworker wrote the mother a letter suggesting that she get therapy for her children. The family is now enrolled in a Mental Health Intense Services program. The children are continuing to be sexually reactive with each other and with neighbor children. Mental Health has requested that Child Protection place these children in foster care. Child Protection refuses because of the risk they would present to other foster children and foster families. Child Protection recommends that these children receive services in a residential treatment center 250 miles away. The Mental Health clinician will not sign necessary paper work because it is against Family Preservation policy to place children out of the community. There are no residential programs for children under twelve within a 250 mile radius.

In the eight month course of this project the Department received 35 referrals alleging sexually reactive behavior in children under ten. Eighty-six children were involved reports.

A survey of caseworkers indicated that there were no standard procedures or guidelines in this agency for handling referrals that allege sexual victimization by a child under the age of ten (see Appendix A). The caseworker survey identified forty-six children under the age of ten who engaged in sexually reactive behaviors. Caseworker intervention ranged

from not assessing the child but referring the family to therapy to filing a Dependency and Neglect petition because the child was beyond the control of the parent. Some children and their victims received treatment. Some did not. Unless a Dependency and Neglect petition is filed a caseworker will not follow a case until therapy is completed. Once a therapist is located and a funding source secured the worker will usually close the case.

Caseworkers had many concerns about agency involvement and their role in these types of cases. For example, neither caseworkers nor law enforcement may interview a minor suspect of a crime without the consent of the guardian. While a child under the age of ten can not be a suspect in a crime, the purpose of a Child Protection interview would center around the child's culpability for inappropriate behaviors. The legal and civil rights of these children and their parents in regard to the authority of the caseworker to assess the child have not been clearly established.

There was a rift between caseworkers who place children and caseworkers who license foster homes over whether children who exhibit sexually reactive behaviors should be allowed to continue in their placement when these behaviors are first discovered in foster care. Many foster homes and receiving homes want to maintain their homes at maximum capacity for financial reasons. Therefore, it is unrealistic to have only

one child in a home. A sexually reactive child is a risk to other children. It is counter-productive to treatment for a sexually reactive child to be removed from a foster home because of offending behaviors. Children are placed in foster care for a variety of reasons. Even though the reasons for placement may differ, most children feel a sense of loss because of the disrupted placement. Foster care drift, or the bouncing of a child from home to home, has been found to contribute to this sense of loss. Foster care drift is so detrimental to the emotional stability of a child that federal mandates require an administrative review to justify any foster home changes.

Children who display sexually reactive behaviors are similar to sexual abuse victims in many ways. They usually have low self-esteem, do not trust others and cannot set personal boundaries. Sexually reactive children need caretakers who will accept them as an individual child with special needs. Since the child does not have the ability to set appropriate boundaries the caretaker must be committed to helping the child control negative behaviors. Most children will willfully act out in foster care to test the limits. A sexually reactive child may use sexually aggressive behaviors as a power play. If the child is removed from the foster home because of inappropriate behavior the child may perceive that offensive behaviors are a mechanism to control placement. It

is therapeutically important to help these children separate power and control from sexuality.

Caseworkers have not been given clear guidelines on how to initially approach sexually reactive children. Many times offending behaviors are indicators that the child has been a victim of sexual abuse. In therapy it is important to separate victimization issues from perpetration issues.

When working with a victim it is essential for the investigating caseworker to be supportive, noncontrolling and non-judgemental. An investigator should not confront a victim even when statements are contradictory to evidence. One of the most important factors to a victim making a disclosure of sexual abuse is that someone believe the revelation. Sexual abuse violates a victim's perception of reality and sense of self. It is not uncommon for children to report in a disclosure that they fell asleep and then the molestation began. Some children report they were asleep but that they can recall the molestation in detail. This is a common cognitive distortion used by children who do not have the mental and emotional capacity to process the sexual abuse. In many cases the victim cannot accept or believe that a violation has occurred. If an authority figure such as a caseworker expresses doubt about the abuse incident the victim who does not have a firm sense of reality may take cues from the caseworker and deny or minimize the victimization. Sometimes

the perpetrator will try to distort the victim's reality. In some cases children have made disclosures to parents, relatives or friends who did not believe the victim. The investigator must discover the truth, understand inconsistencies and learn details without conveying doubt or blame.

Perpetrators may also have a distorted view of reality. They typically try to assign the responsibility of their actions to someone else. The investigator should not judge the suspected perpetrator. However, the investigator should not allow the suspect to minimize responsibility. Perpetrators are masters of control and manipulation. It is essential that the investigating caseworker maintain control of the interview. It is acceptable to challenge false or inconsistent statements. It is appropriate for the interviewer to let the suspect know when non-credible statements are made. Because there is such a vast difference in the way an investigator approaches a victim as opposed to a perpetrator, it is impractical to ask a caseworker to assess perpetration and victim issues in the same interview. Caseworkers were confused about which issues should be addressed in the initial assessment.

The standard practice in this community is that only children who have made a disclosure of abuse to someone or who present with physical evidence (bruised genitalia, sexually transmitted diseases, etc.) are interviewed for sexual abuse.

These interviews are conducted jointly with law enforcement and Child Protection. Literature and practice suggest that many children who display sexually reactive behaviors are not ready to disclose their victimization. However, perpetration behaviors must be addressed because this conduct places other children at risk and because these behaviors are a cry for help. Techniques for assessing adult and juvenile (teenage) offenders cannot be applied to the prepubescent child because of developmental issues.

Causative Analysis

There were multiple reasons for inconsistency of services to sexually reactive children. This agency was funded at 54% of the recommended level. If the agency was funded at the recommended level there would be nineteen more caseworkers in the Service Division. The American Civil Liberties Union has filed an intent to sue the state on behalf of children who are not receiving mandated services because of fiscal decisions. Until the disparity between funding level and need is resolved caseworkers must continue to prioritize their caseloads. Cases of children victimized by adults usually took precedence over cases of children victimized by other children.

Caseworkers were encouraged to attend workshops and courses that address all aspects of child sexual abuse. However, there had never been an educational program presented locally that addressed the role of Child Protection in cases

of sexually reactive children. The problems of children who victimize other children are not issues addressed in new worker training. New caseworkers must have a degree in the human services area and experience working with children. There is no expectation that new staff would have had training in the dynamics of the sexually reactive child.

Child sexual abuse is a problem that society has recently, within the past fifteen years, begun to recognize and address. Many aspects of this problem have not been fully researched and understood. There is a lag between Child Protection practice which identifies the problems in the field, and the research which provides a framework for understanding these problems. An example of this lag is the knowledge base surrounding females who molest young children. Many caseworkers would agree that the most damaged children they have seen are children who have been molested by their mothers. Current literature such as Faller (1986) and McCarty (1986) document the pathology caused by female sex offenders. Only a decade before Mathis (1972) wrote that there were few female perpetrators of child sexual abuse and that the actions of female offenders did not have lasting effects on children.

During the 1980s the research community focused on the juvenile sex offender. Child Protection workers are seeing aggressive sexual behaviors in prepubescent children. The research community is aware of this problem but the tools that

the practitioner needs to identify and evaluate these children are still in the developmental stages. Hindman (1992) is in the process of developing a scale that assesses culpability for children between the ages of five and eighteen. This scale differs from culpability scales used for adult offenders because it takes into account the intellectual and social functioning of the young offender. Hindman (1989) found that most courts based culpability of adult offenders solely on the acts of perpetration and not on the effects to the victim or intent of the victimizer. To determine adult culpability behavior is assessed according to degree of consent, violence, penetration and frequency. For young children assessment and evaluation tools must consider child development stages. Without standardized assessment tools caseworkers are asked to make decisions for children and families that may appear arbitrary and subjective.

The intent of the group that lobbied to change the state statute to make Child Protection responsible for assessing abusive behaviors of children under the age ten was to provide protect for both the victim and young offender. Neither the State statute nor the guidelines sent to counties outlining legislative changes addressed social casework practice as it pertained to the young perpetrators.

For the past three years this agency has been in a transformation process. New leadership introduced a different

agency philosophy. New technology was added. This forced workers to see their work in a different manner. There were four organizational restructures in the past three years. The latest reorganization was patterned after a down-sizing model. Child Protection is now accomplished by two autonomous teams that are able to identify problems and set priorities. In the past the focus was on bureaucratic concerns. Many caseworkers believe that the agency was now ready to focus on social casework issues. The intake team identified two areas of major concern - caseworker inconsistency in approaches to neglect cases, and lack of protocol in cases concerning sexually reactive children.

Another reason that sexually reactive children did not receive appropriate services was that there was not a vocal concern in the community advocating for these children. Society is not convinced that latency age children can engage in sexually offensive behaviors and that these behaviors could have lasting effects on both the victimizer and the victim. Parents, teachers and caretakers of young victims and offenders are reluctant to report perhaps because they are in denial about what they witnessed or what their child reported.

Relationship of the Problem to the Literature

Child sexual abuse is a multidimensional problem. Sexual crimes against children can range from fondling to penetration; from child pornography to child prostitution.

Infants and preschool children are not exempt from any and all types of sexual abuse. Society is in the infancy stage in its understanding of the dynamics of child sexual abuse. There is still much debate concerning what are legally, morally and/or culturally acceptable sexual behaviors.

It was once believed that sexual abuse was the victimization of a female by a male. Female perpetrators and male victims are under-represented in the human service systems and, therefore, until recently these populations received little attention by the research community. Smith (1987) attributes cultural myths such as sex-role stereotyping and homophobia as factors that keep young males from disclosing and seeking treatment for sexual abuse. In this society masculinity is equated with power. A youth who is over-powered by a child molester may question his own masculinity. He might believe that it is better to endure the humiliation of the abuse in silence rather than to admit to helplessness. When a youth experiences victimization by a perpetrator of the same sex, fears about homosexuality may arise.

Other social factors that contribute to children's hesitancy to disclose sexual abuse are the double messages and misinformation that parents give children about sex. Sexual behavior is learned behavior. Yet, according to Zilbergeld (1978), most men report that their parents became anxious or

uncomfortable when discussing sex with them. Children learn early in life that talking about or showing any interest in most sexual areas will produce discomfort in adults.

An area of child sexual abuse that is recently receiving more attention is abuse involving a female perpetrator. Finkelhor (1984) estimated that 5% of the sexual abuse perpetrated against girls and 20% of the abuse of boys is committed by females. Lawson (1993) reviewed the clinical literature on mother-son incest. It was found that these cases were usually not reported to Child Protection and in instances where they were reported, the allegations were not handled in a serious manner. This review suggested that mother-son incest cases are not accurately reflected in child abuse statistics. McCarty (1986) profiled 21 incestuous mothers. Eleven mothers victimized their daughters, eight exploited their sons, two abused both sons and daughters. All but two incestuous mothers described their childhood as physically and sexually abusive. About a third of this sample had alcoholic parents or multiple caretakers. Eight of these women had a history of mental illness. The median age of the victims was 6.4 years for females and 9.6 for males.

Faller (1987) analyzed data from 40 female perpetrators. Over 60% of this sample admitted to victimizing more than one child. Seven of these women suffered from mental illness. Seventy-one percent of this sample reported being victims of

childhood sexual abuse. In 72% of these cases there was a male co-offender. Faller found that the male usually instigated the abuse and took a leadership role. However, the children exhibited more emotional distress when they disclosed the female role in polyincestuous cases. Female perpetrators are less likely than males to use force. Therefore, society has minimized the impact of female molesters. Mayer (1992) cited cases of victims with severe psychological damage because of mother-daughter or mother-son incest.

Mathews, Matthews and Speltz (1989) identified three typologies of female offenders, the teacher/lover, the predisposed and the male-coerced. The teacher/lover is interested in non-related preadolescent or adolescent boys. Until recently older woman/male child sexual encounters were not looked upon by this society as a form of child abuse. This type of woman is capable of sustaining healthy adult male/female relationships but enjoys the power and status of being in a dominant position in a sexual relationship. The predisposed type is a woman who abuses young children, usually her own or close relatives. She is typically a neglectful parent who confuses her role as caretaker with her need to be taken care of. Thus, the parent/child relationship is reversed. These women have a hard time maintaining long term relationships with men. They usually have a series of short term unfullfilling relationships. The male-coerced female

offender has a victim profile. She uses her children in a fashion to please her male partner. Domestic violence and/or physical child abuse is common in these relationships.

Studies of female perpetrators are important contributions to the knowledge base of child sexual abuse because they challenge the myth that the female is always the protector of children. Childhood psychopathology appears to be greater in families where the female is actively participating in the sexual abuse of children.

Adult male sex offenders interviewed by Groth & Freeman-Longo (1979) indicated that their deviant behaviors started in their teen or preteen years. Abel and Rouleau (1990) reviewed 561 case histories of convicted male sex offenders. Over 50% of the pedophiles committed their first deviant sex act prior to age sixteen. Duran (1992) reported that one out of every six people arrested for sexual assault in this state is under eighteen years old. The typical young offender is fourteen with seven victims. The average age of the victim is six. In 96% of these cases the victim and offender are acquaintances, friends or relatives.

In order to understand adult offenders Kercher and Long (1991) have attempted to categorize this population according to clinical profiles based on characteristics, motivation, victim selection criteria and method of operation. Johnson (1992) has categorized the juvenile offender population

according to their internal and external dynamics. The first group of offenders are youth who come from sexually confusing backgrounds. These children usually exhibit a variety of inappropriate behaviors. They are not fixated on younger children but are interested in experimentation. Their sexual acts are opportunistic and usually non-violent.

The next group is composed of youth who have been diagnosed as having conduct disorder or oppositional disorder. These children typically come from homes where there is domestic violence. Their parents may have been sexually abused and have poor sexual boundaries. They may have a series of lovers. Sex and aggression are paired. These children act out in many ways. Sexual aggression is a way of expressing anger. It is impulsive behavior.

Children who engage in sibling incest are another distinct group. The victimizer is usually enmeshed with a scapegoating mother. The victim is the favorite child. The older child molests the favorite child out of anger towards the mother.

Children who have been physically and emotionally abandoned may molest because of feelings of hopelessness and depression. These children reside in foster, group, or residential homes where the caretaker relationships are superficial. The hopeless/depressed molester will befriend a child then hurt the child to keep an emotional distance.

Children who are sexually preoccupied seek out sex for pleasure, not control. This group describes early sexual interaction with an adult as a pleasant, non-abusive experience. Often these children engage in compulsive behaviors such as voyeurism or exhibitionism. They bribe their victims rather than use force or intimidation.

Sociopathic victimizers experienced severe early childhood emotional abuse with frequent unpredictable episodes of physical and sexual abuse. These children have highly developed survival skills. They can be charming, well-socialized and bright. They have no victim empathy.

There is a category of youth who molest only in groups. They have a poor sense of self and a great need for external affirmation. Their acts can be very violent as there is no personal responsibility. Aggression is a valued trait of the peer group. Sexual offenses are committed to gain peer approval or acceptance.

Violent youth who molest have a history of anti-social behavior. They have witnessed or participated in violent sex. They are filled with rage. They blame their victim and are in denial about their behaviors. They are likely to use drugs and alcohol.

Finally, there is a group of children who are adult focused. They initiate inappropriate sexual interactions with adults.

Juveniles who fit the characteristics of these groups need appropriate treatment to learn ways to control their behaviors and to correct their distorted thinking. Lane (1991) believes that younger children who exhibit sexually offending behaviors also need treatment. While young perpetrator treatment addresses the same issues as juvenile offender therapy, it should be conducted in a different format because of the cognitive level of these children. Lane compares and contrasts prepubescent sexually reactive children with adolescent perpetrators. These populations exhibit similar behaviors, motives and distorted thinking patterns. The difference lies in the degree of sophistication of their offending behaviors, their understanding of the actions, and the reaction of society.

Ryan (1992) suggests that prepubescent sexual aggression is often overlooked because adults in this society refuse to recognize the sexuality of children. This is apparent by the void in the academic training of professionals in the area of childhood sexuality. After discussing infancy psychosexual conflicts, most college level child development courses do not address sexuality issues again until puberty. Normal prepubescent sexuality must be understood before deviancy can be defined. In order to develop a clearer understanding of childhood sexual behaviors Ryan (1993) categorized behaviors on a continuum from normal sex play to behaviors that would be

criminal if the acts were committed by adults. Normal sex play for children under ten includes masturbation, peeking at other children or adults while they are bathing or dressing, comparing body parts with peers, and playing sexual exposure games such as "doctor", "mooning", or "strip poker." Genital contact between peers is in the context of a game or a dare. It is limited to touching or rubbing. No coercion or penetration is involved.

The second category includes a preoccupation with sexual themes, attempts to expose other's genitals (pulling another's pants down or skirt up), precocious sexual knowledge, excessive masturbation in front of others and simulating foreplay such as French kissing or petting with dolls or peers. These behaviors occur because too much sexuality is directed toward a child who does not have the cognitive maturity to process this kind of information. This could be the result of sexual abuse. These behaviors could also indicate that the child is growing up in a sexually abnormal environment, i.e., a home in which sexual boundaries are too loose or too rigid.

The third category includes mutual extensive sexual behaviors. These behaviors include the full range of sexual activity including penetration. Many cases of sibling incest are included in this category. The distinguishing factors in this category are that the behaviors are mutually agreed to

and are peer-directed. Usually these children will go to great lengths to keep their activities secret from adults.

The fourth category is the child perpetrator. The sexual behaviors in this category cover the full range of sexual behaviors. The criteria for placement in this category is an imbalance of power. This can be physical power caused by a significant age or strength difference. It can also be psychological domination based on humiliation, guilt or shame.

If the imbalance in power is an imbalance in strength and the stronger child is aggressive, the victim can sustain physical damage. However, in most documented case of sexual abuse between children, physical injuries do not result in permanent damage. Haugaard and Tilly (1988) wanted to determine if there were long term effects of sexual encounters between children. They sampled 1784 college students. Out of this sample 42% reported that they had sexual encounters before the age of thirteen with other children. Negative memories were associated with encounters with strangers, encounters that involved coercion and encounters with same-sex children. Positive remembrances were reported when the partner was a friend rather than an acquaintance or relative. However, if a friend used coercion an extreme negative reaction was reported. Type of encounter had no bearing on intensity of feelings. This study concluded that further study of sexual activity between children is warranted.

Coercive sexual behaviors between children is different from exploratory sexual play. Marshall, Laws & Barbaree (1990) expressed concern that parents and professionals excuse childhood perpetrating behaviors as experimentation or a phase. These children are experimenting with rape, exhibitionism and pedophilia. If there is no intervention many of these children could emerge from this experimental phase with a well-practiced repertoire of deviant behaviors.

Johnson presented studies on two populations of prepubescent offenders. Johnson (1988) furnished data on 47 male children under the age of thirteen who were in treatment for molesting children younger then themselves. These children ranged in age from four to thirteen with a mean age of nine years, seven months. The mean age at the time of the first known perpetration was eight years, nine months.

The following year Johnson (1989) published data on thirteen girls under the age of twelve who were in treatment for sexually reactive behavior with younger children. Their mothers were characterized as having dependent personalities, being victims of domestic violence and suffering from depression. Eleven mothers were victims of childhood sexual abuse. The natural fathers in every case were verbally, emotionally and physically abusive. Five of these girls were sexually abused by their natural fathers. All of the girls had been sexually molested before the age of five. The average

number of victims of each of the girls in Johnson's sample was three. There were twice as many male as female victims. Each girl believed that her actions were more shameful than the behaviors of their molester. Johnson reported that "denial was pervasively employed by these girls. They were almost completely shut off from the negative emotions regarding their own victimization" (p.582).

James (1989) suggests that it is not uncommon for a traumatized child to readily admit to perpetration behaviors while denying personal victimization. The child will allow the therapist to focus on the victimizing behaviors to avoid addressing the more painful issue of being the victim.

Why some children display sexually reactive behaviors while other children with similar childhood experiences do not is a question that is often raised by professionals in this field. Ryan (1992) analyzed the long term effects of child sexual abuse in adults. Long-term outcomes could be categorized into three groups: those with no long-term dysfunctions, those with non-sexual dysfunction such as eating disorders, substance abuse, depression or psychoses, and those with sexual dysfunctions which include sexual perpetration. Correlation tests were run to determine a relationship between long-term effects and numerous factors such as age when abuse first occurred, type of abuse, relationship to perpetrator, age of disclosure, and treatment opportunities. No significant

correlations were found between these factors. However, in a study of 105 young perpetrators Ryan found five significant factors: 1. Children who perpetrate are likely to be victims of childhood sexual abuse. 2. These children are likely to have received inconsistent care prior to exhibiting sexually reactive behaviors. Children who are the highest risks for becoming child perpetrators are children who reside in foster care or residential care due to childhood neglect. 3. These children were raised in non-traditional sexual environments. 4. Parents were described as non-empathic. 5. A statistically significant number of the children in this group had a diagnosis of Attention Deficit Disorder.

It is apparent that more work must be done both in the research arena and in the field to understand the dynamics of sexually reactive children, identify these children and their victims, and provide appropriate care and treatment. Johnson (1989) laments that:

> Child perpetrators, both male and female, remain virtually unstudied and unserved. The social service and criminal justice system have no protocols with which to guide their actions when they come in contact with these children. Most of our society, and that includes mental health professionals, appear to want to deny the existence of these young

children who are acting out sexually and often aggressively to other children. (p.572)

Freeman-Longo and Ryan (1990) point out that this problem can no longer be ignored because parents of victims and of victimizers are holding agencies and professionals accountable for appropriate diagnoses and treatment. Freeman-Longo and Ryan addressed the liability issues that child care facilities, Child Protection agencies, therapists and schools face when they are aware of a sexually reactive child and still allow this child to have contact with other children. Questions about the civil rights of sexually reactive children and their right to confidentiality verses the risk to other children are not resolved. Professionals have been sued by offenders' families for lack of proper treatment, inadequate services, breach of confidentiality and violation of rights. Family members of victims have initiated litigation against treatment centers when their child was violated by a child still in treatment or shortly after treatment was discontinued.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

GOALS AND EXPECTATIONS

The following goals and outcomes were projected for this practicum. The goal of this practicum is to provide more consistent services to children under ten who engage in sexually reactive behaviors with other children.

Expected Outcomes

The outcomes projected for this practicum were:

1. Workers receiving referrals alleging sexual misconduct by a child under ten will be able to determine if the behaviors are within a normal developmental range or if further assessment is warranted. 2. Investigating caseworkers will be able to provide a more comprehensive assessment of sexually reactive children. 3. Child Protection caseworkers will develop an increased awareness of treatment issues and options. 4. Foster parents who accept sexually reactive children will have an increased awareness of safety issues and their role in the treatment process.

Measurement of Outcomes

Outcomes were measured through evaluation questionnaires. These evaluation instruments were patterned after evaluation tools used by institutions of higher learning to assess consumer satisfaction with instructors and course content.

Standardized criteria for screening allegations of sexually reactive behaviors were developed. These criteria were presented in the form of a Screening Assessment (see Appendix G). Staff responsible for screening calls were asked to use the Screening Assessment. These workers were surveyed about their understanding of the screening criteria, their willingness to use this screening criteria, and their belief in the effectiveness of this criteria (see Appendix B).

The first outcome regarding standardization of screening criteria was considered to be successfully met if at least 85% of the workers who screen referrals strongly or mildly agree with the four evaluation statements.

A work session was conducted to enhance the evaluation and risk assessment skills of investigation caseworkers. At the completion of the evaluation and assessment phase participating caseworkers were given an opportunity to evaluate the work session (see Appendix C). For the second outcome of this practicum to be considered successfully met 80% of the participating caseworkers would strongly or mildly agree with the four evaluation statements. In addition, 80% of

the participants would be able to identify three elements that should be considered in assessing risks and three factors to be considered when evaluating sexually reactive children.

The third outcome, Child Protection caseworkers will develop an increased awareness of treatment issues and options, was measured after each caseworker had an opportunity to review the Treatment Options List (see Appendix H). Caseworkers were asked to complete an evaluation survey (see Appendix D). For this outcome to be considered successfully met 80% of the participating caseworkers would strongly or mildly agree with the four evaluation statements.

Foster parents were invited to participate in a work session where daily living and safety issues of sexually reactive children was addressed. At the completion of this work session foster parents were given the opportunity to evaluate the program (see Appendix E). For the outcome that addresses increased awareness of foster parents regarding safety issues to be considered successful met, 80% of the participating foster parents would strongly or mildly agree with the four evaluation statements. In addition, 80% of the participants would be able to identify three safety issues and three precautions to minimize risks.

A manual that contained by-products of this practicum was compiled. This manual contained the recommendations of the Sexually Reactive Children's Panel, a review of the

literature, the Screening Assessment, a training outline for foster parents, the Treatment Options List and a list of references. Child Protection caseworkers were given an opportunity to review the contents of this manual. This manual was disseminated to community professionals outside the agency for review and comments. Five structured interviews with various community professional were conducted. The purpose of these interviews was to elicit feedback about the usefulness of the manual outside the Child Protection system. Disciplines represented included Mental Health, Elementary Education, Early Childhood, Legal and Medical. The highlights of these interviews are presented and summarized.

Data on all referrals alleging sexually reactive behaviors received during the practicum implementation period was collected. This data was analyzed and presented to determine the extent and severity of sexually reactive behaviors among children in this community.

CHAPTER IV

SOLUTION STRATEGY

DISCUSSION AND EVALUATION OF SOLUTIONS

The goal of this practicum was to provide more consistent Child Protection Services to children under the age of ten who display sexually reactive behaviors.

Cantwell (1988) stated that in the Denver area Child Protection receives three to four calls a week concerning children under ten who abuse other children. Unless parents consent these children receive no assessment or treatment. In many cases sexually reactive behaviors are symptoms of sexual abuse. Families like June's, described in Chapter II, *case a*, may be afraid of the findings and consequences of an evaluation. Cantwell suggested that every case of sexually aggressive conduct reported to Child Protection be investigated. Both the victim and the victimizer should receive a professional evaluation, a risk assessment and appropriate treatment.

In order for Cantwell's recommendations to be put into practice in this community, a criteria had to be established to distinguish normal sexual behaviors from red flag behaviors. Some people who make referrals to the Child Protection hot line do not appear to understand that young children are sexual beings with curiosity about theirs and other's bodies. To conduct sexual abuse investigations on children who are not high risk might upset or traumatize healthy children. Assessing low risk children is a poor allocation of scarce resources.

Friedrich, Grambsch, Broughton, Kuiper and Beilke (1991) studied the sexual behaviors of non-abused prepubescent children. They found many types of sexual play in children under five. As children became older and more aware of social norms overt sexual behaviors decreased. This was attributed to children learning and accepting the cultural standards of modesty and privacy as they matured. Sgroi (1988) discussed children's sexual behaviors at various developmental stages. Ryan (1992) placed childhood sexual behaviors on a four step continuum from normal behaviors, to behaviors that should be monitored, to behaviors that should be evaluated by a professional, to behaviors that require Child Protection intervention. Child Protection personnel who provide phone coverage should have an understanding of normal and deviant sexual behaviors in children since providing child sexual

development information to concerned parents is a legitimate function of a screener.

Once it is determined that the allegations warrant an investigation the investigating caseworker should assess all victims and the alleged perpetrator. Ross and Loss (1991) state that there are four reasons for professional assessments of juvenile perpetrators - to help the offending child, to protect the community, to assist in case disposition, and to determine treatment goals. Currently there are no standardized assessment tools. The quality of assessment depends upon the skill of the interviewer.

Even though many juvenile offenders are victims of sexual abuse, the assessment interview of a perpetrator is different from the assessment interview of a victim. In a victim interview it is important for the caseworker to make the child as comfortable as possible. The victim should be allowed to control the interview. Eye contact is sometimes intimidating to the victim and, therefore, is not necessary. The interviewer should never convey the notion that the victim was responsible for the abuse. In a juvenile perpetrator interview it is good practice to allow the child to experience some level of anxiety. The interviewer should be in control throughout the entire session. Maintaining eye contact is essential. The interviewer must not absolve the offender from responsibility or minimize the problem.

The purpose of the initial interview with sexually reactive children had never been clarified. Investigators knew that they could not conduct a perpetrator and a victim interview at the same time. No investigating caseworker in this county had been trained to conduct interviews with perpetrators. Although many caseworkers have observed perpetrator interviews, in this county it is the responsibility of law enforcement to conduct these interviews. A change in the Children's Code in 1992 placed the responsibility of assessing child perpetrators under the age of ten with the Department of Social Services. Child Protection caseworkers voiced concern because they had not received training on how to evaluate perpetrating behaviors. Caseworkers believed that they needed specific training that would allow them to make accurate assessments without traumatizing the child.

Working with traumatized children can be challenging. Ryan and Lane (1991) expressed concern for the professionals who chcose to do investigative and therapeutic work in the field of sexual abuse. The nature of the work is intrusive and voyeuristic and can have major negative effects in the professional's personal and social life. Investigators and therapists become sensitive to control and manipulation issues because they are constantly working with clients who can only

relate through power games. This can cause the professional to be overly-sensitive in personal relationships.

Listening to the abhorrent details of sexual abuse can bring up issues of past victimization. Professionals may develop defense mechanisms to block personal and transformed pain. Ryan and Lane recommend team work, peer support, and appropriate on-going training. They caution that, "Sexual abuse has enough casualties. Colleagues must take care of themselves and each other" (p.427).

It is important that the self-managed teams of this agency are aware of the effects that direct work in the area of sexual abuse can have on the individual. However, it is just as easy for teams and systems to go into denial as it is for individuals. Verstraete (1992) addressed caseworker burnout and the role organizational systems play in fostering this disorder. Families where children are sexually reactive are usually multi-dysfuctional. Organizations that serve these populations should have an institutionalized plan to help staff recognize and avoid burnout.

Investigating caseworkers provide the first step in the healing process. They identify and validate the problem to the victim and the family. Hemphill (1993) found that juvenile sex offending can not be defined by behavior alone. Relationship dynamics, cognitive schema and impact to the victim must also be assessed.

Investigating caseworkers must decide if court involvement is a necessary intervention to insure treatment. Cunningham and MacFarlane (1991) stated that they had limited success in working with children who were not under either civil or criminal court orders to complete treatment. Since children under ten in this state cannot be held accountable for behaviors that would be considered criminal if committed by an older child, the only way to obtain court orders would be to confirm neglect because of lack of supervision on the part of the parents. This is an area where there is not uniformity of practice among investigating caseworkers.

Children who display sexually reactive behaviors may have an array of personal and family problems. Treatment for these children must address all the factors that contribute to the child's misbehaviors. Knopp and Lane (1991) advocate for specialized early intervention that takes into account developmental factors, family systems, prior victimization and the mental health of the child.

For a sexually reactive child to remain safe in the home the primary caretakers must become a part of the therapeutic process. In the examples described in Chapter II, the issue that was in dispute in the professional community in *case c* was not the need for placement, but the type of placement needed. The mother, who was the primary caretaker, was chronically depressed and could not provide the level of

supervision necessary to make the home environment safe. Until the safety issue was resolved any type of treatment was premature.

In *case b* Rose was not making progress in individual therapy because individual therapy was not enough. Rose should have been in peer group therapy to confront her denial. Both her father and mother should have been in family therapy to help Rose clarify sexual boundaries and to support and reinforce therapeutic gains. Most treatment programs address the issues of the victim, the perpetrator and, in some cases, the non-offending spouse. According to Allen and Lee (1992) when there are sexual abuse issues within a family, even if the perpetrator is extra-familial, the family system should be assessed to determine if the family structure places members at risk.

Knopp and Lane believe that sexually reactive children need a combination of family, group, and individual therapies because their behaviors are usually a manifestation of multiple stressors. Gil (1987) concurred that the treatment of young offenders is rarely successful without the investment of the primary care giver. Gil has developed a guide book which outlines parental responsibilities. Kahn (1990) has prepared a twelve step treatment manual for young offenders. It is a group therapy model which stresses education regarding legal/illegal behaviors and the sexual offense cycle. Each

participant must develop an individual prevention plan. The treatment groups should be composed of approximately six same-sex children who are at similar developmental stages.

MacFarlane and Cunningham (1988) believe that a treatment program for young children must address self-esteem, problem solving, sex education, anger-management, victimization, and perpetration. Materials should be presented from the general to the specific in order not to overwhelm the young child. Esterl and Pagano (1992) state that treatment for sexually reactive children is a slow, long process that rarely can be completed in less than a year. While it is important to address and stop perpetrating behaviors initially, therapy cannot be considered successful until the child had worked through personal victimization issues.

A community that is invested in early treatment and prevention of sexual abuse should have an array of age-appropriate groups. No one treatment facility in this community has accepted the challenge to provide this variety of services. It was difficult for caseworkers to know which facilities offered services to sexually reactive children and their families.

Salter (1988) believed that early perpetrator treatment programs in the 1970s had limited results because they were based on psychotheraputic models that did not take into account the unique dynamics of sex offenders. Conventional

therapeutic models allow the client to define the problem and set the pace and course of treatment. The therapist is non-judgemental and operates on a trust basis. Sex offender therapy is more successful if the therapist maintains control by setting goals and defining limits. The therapist should take an explicit value stance and must always be on guard for manipulations. Adolescent and adult models of treatment stress the need to identify the internal processes that occur before and during an incident. Treatment is deemed successful when the perpetrator develops victim empathy. This type of abstract thinking cannot be expected of a child under the age of twelve. Treatment for young children must be concrete and focused on behaviors. According to Berliner and Rawlings (1991) the first level of treatment for young offenders is developmentally consistent sex education which includes clear guidelines of acceptable sexual behaviors. The child must learn that sexually inappropriate behaviors are unsafe behaviors that will lead to consequences. The first task of the caretaker is to make the home environment safe. This may necessitate a high level of supervision, strict bathroom rules, rearrangement of bedrooms, and safeguarding or removing pets. School personnel may need to be contacted and fully informed about the child's need for supervision.

The second task of therapy is for the child to be given a framework for understanding sexual misbehavior. Sexual

victimization is not random behavior. There is a planning process. While the young child may not understand this process, usually concrete elements associated with the molesting event can be identified. The caretaker must help the child to overcome the need to perpetrate when molesting conditions are present. For example, if a foster child engages in perpetrating behaviors after court-ordered home visits, the foster parent should be extra vigilant during this time. It would be therapeutic to this child for the foster parent to plan adult-supervised and anger-reduction activities following visitation.

There must be firm rules about family boundaries. There should be consequences for violating these rules. These consequences must be humane and related to the offending behaviors. Isolation or physical punishment may produce anger or resentment in sexually reactive children. This anger and resentment could place the child in a state of mind to re-offend. Sexually reactive behaviors can be so disturbing to adults that many times they respond in inappropriate ways. Sometimes the behaviors are minimized or ignored. The adults can be in denial about behaviors that they have witnessed. Other times the caretaker may over-react. Children soon learn that they can receive attention by becoming sexually aggressive. Physical punishment should never be used because aggression and violence should never be paired with sex even

in the context of a negative consequence. Physical discipline may enhance the feeling of powerlessness and reinforce the belief that control or power is obtained through aggression.

Many children in foster care are victims of sexual abuse. Hibbard and Hartman (1992) found that sexual abuse victims between the ages of four and eight display more behavioral problems that non-abused children. Areas where there was a statistically significant difference between sexually abused children and non-abused children include demand for attention, physical aggression, amount of sex play, sudden mood changes, strange behaviors, sleep related problems (trouble sleeping, nightmares), and poor school work. Gil (1991) has outlined the types of internalized and externalized behaviors that are commonly seen in sexually abused children. Internalized behaviors manifest in eating disorders, dissociation, sleep disorders, phobias, over-compliance and self-mutilation. Externalized behaviors include aggression, hostility, torturing animals, fire-setting and sexualized behaviors.

Long (1987) discussed how inappropriate sexual stimulation at a young age interferes with the progression of development. Sexually abused children may appear pseudo-mature. They look and act older and more sophisticated than their age but there are many gaps in their emotional and cognitive development.

Children in foster care may be grieving the loss of their family. Sexually reactive behavior could be a pathological manifestation of the child's need for intimacy. Behavior modification programs that call for time-out or isolation for inappropriate behaviors will further alienate and frustrate a vulnerable child. It is critical to obtain an accurate assessment in order to build a treatment program based on the child's cognitive distortions. Schatz and Hartzell (1992) recommend that foster parents intervene immediately in a calm, direct and simple way, when sexually inappropriate behavior is discovered. While separation of the children may be appropriate, isolation of the offender or time out away from human contact may increase the foster child's sense of shame or worthlessness. A negative behavior should always be replaced by a positive one. For example, if a foster child were picking his nose, the foster parent would teach the child how to use a handkerchief. Most foster parents have not had the need to learn how to replace sexually inappropriate behaviors with positive behaviors. Training which includes brain-storming and role-playing is necessary to insure that the foster parent reaction is natural and supportive.

Cognitive distortions are mental defense mechanisms that sexually reactive children have developed in order to survive in unpredictable environments. Many children who have been sexually abused have not come to terms with their own

victimization. Some of these children may deny that they have been victims, but readily admit that they are victimizers. These children may be identifying with their perpetrator while suppressing or repressing their victimization experience. Sexuality and sexual behavior become the means to power and control. When the child is feeling powerless, sexual aggression appears to be the only way for the child to gain control. Ryan (1989) outlined a cycle of sexual abuse based on distorted thinking. It is important for foster parents to understand the cycle of abuse, since it will be their job to provide the external controls, build self-esteem, and confront distorted thinking. When foster parent are not included in the professional treatment team, the risk of a disrupted placement and failed therapy is high.

Description of Selected Solution

Synthesis of the solution literature suggested that more consistent services to sexually reactive children could be achieved through interventions at four service points: screening, investigation, treatment, and foster care.

Workers who provide telephone screening services should be applying standardized criteria in responding to calls about sexual misconduct of children. Many times parents of young children call because they are alarmed by any type of sexual behavior between children. The screener must decide whether the caller needs education and reassurance, whether the child

should be referred to private therapy, or if Child Protection intervention is warranted.

Child Protection caseworkers from different service teams were asked to participate on a panel to develop agency standardized criteria for screening calls concerning sexual misconduct of children. A Screening Assessment was developed with input from the panel and the intake unit. This screening tool was shared with all workers who have screening responsibilities. Screeners were asked to evaluate the Screening Assessment.

Child Protection investigators voiced numerous concerns about assessing sexually reactive children. Child Protection workers have the right to interview a child without parent knowledge or consent if the child is the subject of an abuse/neglect allegation or a sibling of a subject. Juvenile perpetrators have the same rights as adult offenders in the investigation process. They have the right not to speak to an investigator. If they agree to an interview they are not obligated to respond to any questions that they feel uncomfortable answering; they may terminate the interview at any point and they have the right to have an attorney present. Suspects under the age of eighteen cannot be interviewed without their parent's consent.

If sexually reactive children under the age of ten were considered victims caseworkers could interview them without

parent permission. However, all victim interviews in this county are teamed with law enforcement. Law enforcement cannot do interviews unless there is physical evidence that a crime has been committed or unless the child has made a disclosure to someone about being victimized. Casework practice in this community validates the observations of Johnson (1989) and James (1989) that many child perpetrators are not ready to make disclosures about their victimization. These children are more likely to admit their role as an aggressor than as a victim. A caseworker who interviews a victim without law enforcement present is in violation of agency policy. A caseworker who interviews a child about perpetration issues without the consent of a parent may be violating the child's and parent's civil rights. Contact was made with the County Attorney and the State Department of Social Services to obtain a clearer interpretation of the legal parameters of the Child Protection investigator.

Investigating caseworkers receive extensive training on victim issues before conducting a sexual abuse interview. There is no standardized training at either the state or county level that clarifies the issues and dynamics of a young sexual perpetrator. Caseworkers felt that without a generic knowledge base valid evaluations and assessments could not be completed. Caseworkers attended a day long work session that addressed the issues and dynamics of sexually reactive

children. Caseworkers were given the opportunity to evaluate this work session.

After a problem is identified the caseworker is obligated to assist children and families in locating and accessing resources to mitigate the problem. Caseworkers expressed frustration in identifying resources for sexually reactive children. A resource survey was developed and sent to treatment facilities locally and state-wide that provided services to sexually reactive children. A detailed explanation of these resources including criteria for acceptance, program description, qualifications of staff, and cost was compiled into a Treatment Options List. This information was disseminated to all caseworkers. Caseworkers were given the opportunity to evaluate the Treatment Options List.

Berliner and Rawlings (1991), Knopp and Lane (1991) and Gil (1987) concur that therapy for sexually reactive children is rarely successful unless the primary caretaker is invested in the treatment process. Although children in foster care may have an array of issues to work through in therapy, if they are acting out sexually this becomes the initial focus of treatment. Foster parents should have a basic understanding of the dynamics of sexual abuse and sexually reactive behaviors before a child with sexual issues is placed in their care. Foster parents should have a clear understanding of their role as the primary caretaker and as a member of a treatment team.

Foster parents were invited to attend a day long work session that addressed the dynamics of sexually reactive children and the foster parent role. Participating foster parents were given the opportunity to evaluate this work session. From this work session and the literature review, a foster parent training module was developed. It was intended that this training module would be used on a regular basis in the future to insure that new foster parents have a basic understanding of sexually reactive children and their role in the treatment process.

All materials developed in the course of this practicum: the Literature Review, Screening Assessment, Panel Recommendations, Treatment Options List, and Foster Parent Training Guidelines were collected into a manual. This manual was disseminated to all agency caseworkers, many community professionals and caseworkers from other counties. The manual was formally reviewed by five community professionals outside of Child Protection.

Finally, all referrals received during the eight month implementation period were analyzed to document the extent of sexually reactive behaviors among children in this community.

Report of Action Taken

The implementation phase began with a memo to all caseworkers and administrators explaining the project and requesting participants on the Sexually Reactive Children's

Panel. The memo also requested that staff list any community resources that they had used to provide services to sexually reactive children. Ten copies of the practicum proposal were disseminated throughout the agency. Nine workers, at least one from each team, responded to the request to serve on the Panel.

The practicum proposal suggested that the Sexually Reactive Children's Panel meet two times in a two month period to develop screening criteria. The Panel was to reconvene after a three month implementation period to evaluate the screening tool. The topic "sexually reactive children and agency response" generated so much discussion and raised so many issues that this group met eight times over a six month period. This Panel undertook the task of becoming an advisory committee for all phases of this practicum.

The discussion at the first Panel meeting centered around the process. Some thought it would not be possible for this agency to adopt policy based on academic and research principles and field work experience. Caseworkers discussed the sexually reactive children on their caseloads and their frustrations with different parts of the Child Protection system. For example, ongoing workers expressed frustration with the foster care system because many times ongoing workers are asked to find an immediate new placement for a foster child who begins to act out sexually. The foster care

caseworker expressed concern that foster parents were investigated for neglect when foster children molest other children. It was pointed out that natural parents are rarely held responsible for their children's behaviors. The adolescent team representative commented that developmentally delayed juvenile perpetrators were cognitively on the same level as sexually reactive children. These children fall through the cracks in the system because perpetrating behaviors may be only one of many problems these children present. Other agencies may refuse to serve sexually reactive children in order to protect other children.

The factor that seemed to motivate each member of the Panel to work together was the commitment to study this problem from the perspective of each service unit. The goal was not to place blame for service gaps, but to identify problems, suggest solutions and to evaluate the impact of the proposed solutions from the perspective of each service delivery area. Each Panel member agreed to read two articles about sexually reactive children and to come to the next meeting prepared to develop screening criteria.

Discussion at the second Panel meeting centered around the discrepancies in the literature between what are considered normal sexual behaviors in young children, what are considered abnormal behaviors, and what are clearly identified as perpetrating behaviors. Several other issues were raised

and debated in this session. The Panel attempted to define what would constitute coercion, force, manipulation and intimidation in young children. One worker noted that some children are able to form a network of peers who will engage in sexually inappropriate behavior. When the behavior is discovered the adults give frightening signals to the children. The adults, through actions and words, convey that this behavior is extremely bad and shameful. This encourages children to become defensive and to look for someone to blame in order to keep from getting into trouble. Caseworkers felt strongly that not all sexual interaction between prepubescent children was an indication of sexual abuse or sexual perpetration and that children who do not have strong indicators of sexual abuse or sexual perpetration should not be subjected to a Child Protection investigation.

The discussion drifted to the value of labeling children as sexual perpetrators. It was felt by some Panel members that sexually reactive behaviors that were extreme in young children were a symptom of an unhealthy life style and a cry for help. To label a young child as a perpetrator or sexually reactive could stigmatize the child. Teachers and other caretakers, neighbors and peers might reject the child if the label became known. Other workers pointed out that it was important to label behaviors in order to secure appropriate services. Current treatment philosophy expressed by Kahn

(1990) and Berliner and Rawlings (1991) stress the need to identify the behavior, label the behavior as unacceptable and help the child identify factors that lead up to the unacceptable behaviors.

The group attempted to identify factors that would clearly indicate perpetration behaviors. Five factors were brought up for discussion - power imbalance, use of force, premeditation, a sexual act and repetitive incidents after a child was asked to stop. These factors can be assessed in an investigation but they may not be known at the referral stage.

At this point the Panel decided that they did not have enough information about sexually reactive children to make recommendations for screening criteria. The panel decided to invite a consultant knowledgeable in the area of sexually reactive children to facilitate a work session. Gail Ryan from the C. Henry Kempe National Center for the Prevention of Child Abuse and Neglect was chosen because of her involvement in the Perpetration Prevention Project and her experience as a writer and researcher in this field.

Concerns about sexually reactive children in foster care dominated the third session. Field experience suggests that there is a correlation between sexual victimization and sexual perpetration. Many children in foster care are victims of sexual abuse. Since this is a population of children that has a greater number of sexually abused victims than the general

population, the Panel discussed the necessity of assessing all sexualized behaviors that occurred in foster care. It was decided that the correct procedure would be for the foster parent to report the behaviors to the ongoing caseworker. The ongoing caseworker would consult with the child's therapist to address these behaviors and modify the treatment plan if necessary. If it appeared that another child was victimized, the ongoing worker would make a referral to the investigation unit to assess a new victim. Both investigation and ongoing workers would share with foster parents their knowledge about the child's past sexual victimization and level of risk for perpetration.

The fourth Panel session was devoted to preparation for the Gail Ryan work session. Ms. Ryan suggested that caseworkers and foster parents attend the session together to develop a common knowledge base.

In order to satisfy the second outcome pertaining to providing more comprehensive assessments, in the second month of the implementation period the investigation team allotted a staff meeting to the topic of assessing sexually reactive children. Investigation caseworkers expressed frustration over the ambiguity of the statute that made county Departments of Social Services responsible for assessing young perpetrators. This statute gives the caseworker the authority to assess victims of young perpetrators. The statute seems to imply that

young perpetrators should be assessed for victimization. However, county policy mandates that suspected sexual abuse of children should be investigated jointly with law enforcement. Law enforcement, as per county agreement, will only instigate an investigation if the child has made a disclosure to someone. Field experience suggests that until a child is ready to make a disclosure, a sexual abuse assessment is premature.

Caseworkers felt they were being placed in legal jeopardy. The statute does not give the caseworker the authority to interview a child for perpetrating behaviors. If caseworkers were assessing children for perpetrating behaviors it would seem that they should have parental consent. Juvenile perpetrators cannot be interviewed without parental consent. Adults suspected of sexual misconduct have the right to have an attorney present in the investigation interview. A county Department of Social Services in this state has been named in a lawsuit because a caseworker assessed a child for perpetrating behaviors without parental knowledge.

Investigators expressed discomfort with the lack of agency guidelines. Until guidelines are provided investigating caseworkers agreed that they would assess young perpetrators as victims of neglect. If parents know about sexually reactive behaviors but do nothing to secure treatment or provide a higher level of supervision, the parent could be considered neglectful. Caseworkers would report the findings of their

investigations to the parents of all children who were interviewed and make professional recommendations for any needed interventions.If during this neglect investigation the child disclosed victimization, the caseworker would take only as much information as the child freely offered. The investigating caseworker would become the reporting party of sexual abuse. This disclosure would be treated as a new referral of child sexual abuse and handled in the established manner.

At this meeting investigators voiced concern that they had not received any training on how to assess perpetrators. This concern was brought to the attention of Gail Ryan. Ms. Ryan agreed to devote a portion of the work session to initial assessment of sexually reactive behaviors in young children.

The third goal of this practicum was to help Child Protection caseworkers develop an increased awareness of treatment issues and options. In order to achieve this goal a survey of community resources was conducted. A resource survey was designed (see Appendix F). This survey was reviewed by the Panel and sent to 21 service providers. A preliminary list of the respondents was compiled and reviewed by the Panel, whose members made several suggestions for additions to the list. These resources were contacted and included in an updated list.

The Panel expressed concern that agency distribution of a resource list would be construed as agency endorsement. They felt that it would be misleading to offer an agency endorsement for services based on self-reported information. Therefore, the Panel recommended that the Treatment Options List contain this disclaimer: "The following information is the result of a survey taken of community providers willing to work with sexually reactive children under the age of ten. Information about service modalities, program philosophies and experience was self-reported. This list is not an endorsement of any provider."

This revised resource list was distributed to all Child Protection and Placement caseworkers. A Treatment Options Evaluation form (see Appendix D) was distributed to these caseworkers. The writer edited the Treatment Options List based on the comments received on the evaluation forms. The Treatment Options List (see Appendix H) was included in the project manual.

Thirty-two people, twenty-three agency staff and nine foster parents, attended the Gail Ryan work session. Areas covered in this session included:

1. Continuum of sexual behaviors in young children
2. Understanding the sexually reactive child
3. Elements of perpetration
4. Responding to sexual behaviors of children

5. Discipline/guidance of the sexually reactive child

6. Protecting others from the sexually reactive child

At the conclusion of this workday caseworkers were asked to complete the Risk Assessment Evaluation (see Appendix C). Foster parents were asked to complete the Foster Parent Program Evaluation (see Appendix E).

A week after the work session the Panel reconvened.The Panel decided that the most useful format for standardizing screening criteria would be a one page risk assessment form. Sexual behaviors were listed and then rated as either low, medium or high-risk behaviors. If the alleged behaviors fell in the low-risk range the screener would ask the referral source to continue to monitor the behaviors. If any behavior in the high-risk range was mentioned in the referral the case would be assigned for investigation. If behaviors were in the medium-risk range caseworkers would staff the referral to determine if the risk was high enough to warrant an investigation.

The presence of high-risk behaviors was sufficient criteria to warrant a Child Protection investigation. However, the presence of high-risk behaviors alone would not be sufficient criteria to confirm that an incident of abuse occurred. When confirming sexual abuse of a child by an adult or juvenile offender the criteria to confirm is that a sexually offensive behavior has occurred and that there is a

four year age difference between victim and victimizer. Consent is not an issue because children under fourteen in this state cannot give consent to sexual relationships with adults. The Panel established criteria for defining a child perpetrator.

All four conditions needed to be present:

1. There is an imbalance of power between children. This imbalance is not limited to age and size. Developmental level, status and circumstances will be considered.
2. There is force or lack of consent.
3. The act is sexual in nature and developmentally inappropriate.
4. Inappropriate sexual behavior is repetitive.

The Panel felt that the Screening Assessment and the criteria to confirm should be reviewed by the investigation team before it could be adopted.

The investigation team held a special session to review the Panel's recommended Screening Assessment and criteria for confirmation. The investigation team agreed with the criteria to confirm. However, the investigation team decided that there should be only two responses to a referral alleging sexually reactive behaviors. Either the referral source should be asked to monitor behaviors and report back if the behaviors continue after the child is asked to stop, or the case should be

assigned for investigation. The Investigation team modified the Screening Assessment and sent it back for Panel approval.

The Panel met again and agreed to adopt the revised Screening Assessment. This Screening Assessment (see Appendix G) was distributed to all Child Protection workers who had screener duties. These staff members were asked to review and evaluate (see Appendix B) the Screening Assessment.

After the Screening Assessment was approved the Panel turned their attention to an outline of suggested curriculum for foster parent training. This outline (see Appendix I) was developed from the literature review and from materials presented at the work session. The Panel agreed that the curriculum content was solid.

There were systemic problems with adopting the curriculum. Foster parents are required to attend an eighteen hour training session before becoming licensed. The current training curriculum covers some issues related to the sexually abused child and the sexually reactive child. However, these issues are not addressed in the separate and intense fashion that the proposed curriculum recommended. The proposed curriculum is a six hour course that could be taught in three, two-hour segments. At this time it is not feasible to lengthen the pre-service licensing training because the demand for foster homes is great and adding three weeks of training could effect the number of homes licensed. Other barriers to

incorporating the new training included lack of personnel to teach the curriculum and concern that new foster parents would find these children too challenging to accept. It was suggested that this training should be offered to more experienced foster parents.

The foster care caseworker made several recommendations about how to incorporate this training. 1. The training program could be offered at the monthly Foster Care Association meetings. These meetings devote a portion of the evening to foster parent education. 2. The agency could offer an annual one day workshop to foster parents. 3. The ongoing caseworker could work individually with foster parents around issues and problems of a specific sexually reactive child. 4. Foster parents who provided care for sexually reactive children could be designated specialized foster homes. These homes would receive a higher level of payment, staff support and training. The foster care worker promised to present these issues to the placement team.

The issue of trainer education was raised. While the current staff now appeared to be well informed about issues surrounding sexually reactive children, there was no agency provision for the training of future staff. This is a concern because the attrition rate in Child Protection is high. Seven of the thirteen caseworkers in Child Protection resigned during the implementation phase of this practicum. The Kempe

Center offers an intense three day training entitled "Understanding and responding to the sexual behavior of children." The purpose of this workshop is to train professionals to replicate the workshop in different communities. The Panel recommended that certain staff positions incorporate attending the workshop as a part of their job description in order for this Department to always have a trainer available.

At the beginning of the practicum implementation phase the writer requested a copy of all referrals alleging sexually reactive behaviors of children under ten. This was done in order to collect demographic information. The writer presented the first six months' data to the Panel. Most of the children named in these referrals were not in foster care. Many of these children and their families needed services beyond an assessment but court intervention was not necessary because parents were willing to seek professional help for their children and provide a higher level of supervision.

The children and families most likely not to receive needed services were children of the working poor. Children receiving public assistance were able to find counselors willing to accept Medicaid insurance. Although some treatment facilities offered services at a reduced rate for low income families, these reduced rates were still not affordable for most families. The Department has one family therapist and one

caseworker to provide services to families not involved in the court system. These workers stated that the majority of their families contained sexually reactive children. These workers expressed a desire to expand the types of services offered to families, particularly to develop a treatment group for these children. There is a long waiting period to receive even basic services. There are no resources to develop new programs.

The Panel expressed concern that they could identify the needs of sexually reactive children and their families and the gaps in the system, but felt that they were powerless to make changes. It was suggested that the Panel identify system deficits and make these problems known to administrators and other community leaders. The Panel agreed to develop a list of recommendations.

The Panel met for an eighth time to develop a list of recommendations. These recommendations were:

1. Propose legislation that would allow caseworkers to assess children under ten for perpetrating behaviors without prior parental consent when necessary.
2. The proposed Screening Assessment should be adopted.
3. All investigating caseworkers should receive training in interviewing and assessing children under ten who are exhibiting perpetrating behaviors.
4. The Department should make a commitment to develop more treatment resources for sexually reactive children.

5. Family Resource staff should attend the Kempe Center workshop on how to train people to work with sexually reactive children.
6. Additional support and training should be provided to foster parents who accept sexually reactive children.
7. An agreement should be developed with the County Attorney that petitions of Dependency and Neglect will be filed in cases where parents fail to provide adequate treatment and supervision of their sexually reactive children.

All the information collected as a result of the practicum proposal and the Sexually Reactive Children's Panel was compiled into the *Sexually Reactive Children and Child Protection Services Manual*. This manual included: the Panel Recommendations, two literature reviews, the Screening Assessment, the Treatment Options List, the Foster Parent Training Outline and a Reference List. This manual was disseminated to all caseworkers and administrators in the Services Division, personnel at the State Department of Social Services, caseworkers in other counties, the Child Protection Team and other community professionals. One hundred copies of the manual were disseminated.

Five community professionals representing different disciplines were asked to read the manual and participate in a structured interview. The professionals and the disciplines they represented included: Medical, a physician's assistant

who provides physicals for children suspected of being sexually abused; Legal, a lawyer in the District Attorney's office; Education, an elementary school principal; Mental Health, a counselor who specializes in working with latency-aged abused children; Early Childhood, the director of programs for developmentally delayed preschoolers.

About four months into the practicum implementation phase the writer was invited to participate in the Child Sexual Perpetrators Work Group. This group was established to clarify issues surrounding the placement of young children on the Central Registry as sexual perpetrators. Central Registry is a state-wide data base used to track victims and perpetrators of child abuse/neglect. The work group consisted of caseworkers and administrators for ten counties, State Department of Social Services personnel and a representative from the Kempe Center.

This group struggled with the same matters that the Sexually Reactive Children's Panel identified as problems in their early meetings. At the first meeting participants voiced concern about the confusion in the field regarding normal and deviant sexual behaviors in children. Much inconsistency was detected in the manner in which counties define, investigate and confirm perpetrating behaviors. This group felt that the 1991 statutory amendment that gave Social Services sole responsibility for the investigation when the

alleged perpetrator was under ten years old contributed to the confusion because each county was defining their responsibility differently. Some county representatives expressed that their county staff has never been trained to conduct perpetrator assessments. Others were concerned because there are no provisions for Child Protection involvement following the investigation.

The Work Group listed the pros and cons of placing a young perpetrator on the Central Registry. The benefits to listing young perpetrators include: motivation for parents to seek treatment, accountability, victim protection, tracking, aid in future investigations, data collection and research. The barriers identified in placing young children on the Central Registry include: lack of a clarity in defining sexual play/sexual perpetration, uncertainty about future uses of the Central Registry, lack of appeal rights, labeling and fairness.

Central Registries were created to track victims of child abuse. The uses of Central Registries have expanded. Today they are used as a screening tool for most child care professions. The Work Group expressed concern about the fairness of limiting an adult's career choices based on childhood behaviors especially if these behaviors were corrected through treatment. Currently a person listed on the Central Registry has a two year period in which an appeal for

expungement can be made. If a child is placed on the Registry and the parent does not appeal this listing in a timely fashion, the child could be left on the Registry and have no knowledge of the listing until it adversely affected a career choice.

The group defined tasks to be addressed at the next meeting. This included defining behaviors, determining if there needed to be a minimum age to place a child on the Registry and establishing a child's rights to appeal.

At the second Child Sexual Perpetrators Work Group meeting the Sexually Reactive Children's Panel's Screening Assessment and definition of young perpetrator was presented. The Work Group agreed that the Screening Assessment identified behaviors that should be investigated. The Work Group agreed that the definition of a young perpetrator identified the criteria to be used for confirming sexual abuse. The Screening Assessment and definition of young perpetrator was adopted for use within this Work Group.

Now that behaviors were defined and criteria for confirming abuse was agreed upon the Work Group could proceed to debate the issues surrounding placement of young perpetrators on the Central Registry. Some Work Group members felt that the Child Protection system was more punitive to children that the Criminal Justice system because records in the Criminal Justice system are sealed after the child's

eighteenth birthday. The advisability of sealing records that contained information about sexually offending behaviors was discussed. Research statistics indicate that the typical young offender is fourteen years old and has confessed to molesting seven victims. Most adult offenders admit that their deviant behaviors began in their adolescent or prepubescent years.

There was a consensus that if children were placed on the Central Registry as an offender they should be entitled to extended appeal rights. The Work Group recommended that there should be no time limit to request an expungement hearing for children who were placed on the Central Registry under the age of eighteen. Children who were placed on the Central Registry under the age of ten should receive an automatic review at age eighteen. This would mean that if there were no confirmed incidents after the age of ten and the County Department of Social Services did not file an objection and request an administrative review, the child's name would be expunged.

Even with the extended appeal rights in place some members of the Work Group expressed discomfort with placing a child under the age of ten on the Central Registry as a sex offender. A third session was scheduled to determine if a minimum age should be set for placement of children on the Central Registry.

The majority opinion at the third Child Sexual Perpetrators Group Meeting was that age was not a factor when

defining a young perpetrator. Factors such as use of force, lack of consent and inequality of status were more appropriate factors to assess when defining a young perpetrator. The group ascertained that if young perpetrators were placed on the Central Registry for tracking purposes that there must be more consistency across counties in the definition and assessment of young perpetrators. Clear-cut criteria must be established and accepted by the counties for confirming sexual abuse by a child under the age of ten. The Work Group agreed to review the Sexually Reactive Children's Panel Screening Assessment and definition of child perpetrator with staff from their counties and to meet together in a month to try to reach a consensus on criteria to confirm a child under ten on the Central Registry.

At the last Child Sexual Perpetrators Work Group meeting the group unanimously agreed that the Screening Assessment defined sexual behaviors between young children and defined how County Child Protection agencies should respond. One amendment was added. It was felt that when sexual manipulation without direct participation was alleged an investigation was warranted.

The discussion of criteria to confirm centered around the necessity to have both an imbalance of power and a lack of consent. Some felt that both factors should be present; others believed that only one factor was enough to confirm that abuse

had occurred. After much discussion a vote was taken. Majority opinion was that both factors needed to be presented to confirm that a child under ten was a sex offender.

To complete an accurate assessment the Sexually Reactive Children's Panel felt that it was not enough to determine that a sexually inappropriate act occurred. It would be necessary tc determine if the alleged young perpetrator had exhibited prior sexually inappropriate behavior and if the child had been instructed that this was not acceptable behavior. Repetition of inappropriate behavior was identified by the Panel as a condition necessary to establish before a child was confirmed on the Central Registry. The Work Group also voted repetition of behavior as a necessary condition, although there were several dissenting votes.

In order to enact the Work Group's recommendations to extend expungement rights to children, there would need to be a change in the State Statute. These recommendations, plus the request for clarification of caseworker authority to interview alleged perpetrators under the age of ten without parental consent, will be presented to the State Department of Social Services legal advisors.

A State Department letter will be prepared requesting that all counties use the Screening Assessment as criteria to determine if allegations of sexual acting out between children should be investigated. This letter will also request that all

counties use the Panel's definition of young perpetrator as the standard for confirming sexual perpetration by a child under the age of ten on the Central Registry.

The Work Group recommended that the State Department develop a training curriculum for all investigating caseworkers. This training program should standardize assessments.

To summarize: The goal of this practicum was to improve Child Protection Services to sexually reactive children under the age of ten. To achieve this goal, four areas of the service delivery system were targets - screening, assessment, treatment and foster care. A Screening Assessment was developed. The State Department of Social Services is recommending that this assessment tool be used state-wide to standardize Child Protection response to allegations of sexual behaviors between children.

Twenty-two agency staff attended a day-long workshop that addressed the issues of sexually reactive children and how to assess behaviors. Criteria for confirming a young perpetrator was developed. The State Department is requesting that all counties adopt this definition as criteria for confirming young perpetrators on the Central Registry.

This community was surveyed for treatment resources for sexually reactive children. A description of the types of treatments, how to access treatment, staff qualifications and

treatment philosophies was compiled and distributed to all caseworkers.

Nine foster parents attended a work session on the issues of sexually reactive children. A training outline was developed. This county is working on a plan to present this training annually to licensed foster parents who provide care to sexually reactive children.

Other issues that present barriers to effective Child Protection Services to sexually reactive children were discovered, discussed and brought to the attention of county and/or state administrators. These problems include: lack of training of new caseworkers in the dynamics of sexually reactive children; ambiguity in the State Statute concerning the authority of the caseworker to assess child perpetrators without parental consent; and lack of community resources for uninsured children.

CHAPTER V

RESULTS, DISCUSSION AND RECOMMENDATIONS

RESULTS

According to the 1991 State Statute, children under the age of ten who sexually perpetrate on other children and their victims are entitled to Child Protection services. Services that these children received were inconsistent because there was no standardized criteria to identify these children and because few agency staff had received any training or information about sexually reactive children. This practicum proposed to improve services to sexually reactive children by focusing on four areas of the service delivery system - screening, assessment, treatment and foster care.

Referrals alleging sexual behaviors between children were handled in an inconsistent fashion because there was no screening criteria that distinguished between normal sex play and perpetrating behaviors. Many people perceive any sex play between children as abnormal. There is a wide variety of sexual activity between children. Behaviors could be normal

sex play, developmentally inappropriate behavior or sexual abuse. The difference between developmentally inappropriate behaviors and sexual abuse is the presence of force or the imbalance of power.

The first predicted outcome of this practicum was that screeners would be able to determine if referrals alleging sexual misconduct by a child under ten were within the normal range or if further assessment was warranted. A Panel composed of caseworkers from each service area studied this problem. With consultation from the investigation unit the Panel created a Screening Assessment. Staff who had screening duties were asked to review this Screening Assessment and complete the Standardized Screening Evaluation (see Appendix B). This outcome would be considered successfully met if at least 85% of the screeners strongly or mildly agreed with the four evaluation statements. Screeners had the opportunity to rate these statements on a 1 to 5 scale. No one indicated that they mildly or strongly disagreed with any of these statements. Screeners were asked to make suggestions for improving the Screening Assessment on the evaluation form. No one made any suggestions but one screener stated, "I appreciate your time and willingness to develop this assessment." Another screener commented that the "no opinion" response was marked for questions one and four because this screener was a new worker and not involved in the planning process. Due to staff

attrition at the time that the Screening Assessment was presented there were only six Child Protection workers assigned to screening responsibilities. Table 1 denotes screener response to the Standardized Screening Evaluation.

Table 1

Standardized Screening Evaluation Results

STATEMENT	RESPONSES	NO.
1. Use of the standardized criteria for screening allegations concerning sexually reactive children was clearly explained.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 4 = 0 = 2 = 0 = 0
2. I am willing to use this criteria for screening calls.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 5 = 1 = 0 = 0 = 0
3. I believe this screening criter .a will help to provide more consistent services to sexually reactive children.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 5 = 1 = 0 = 0 =0
4. Participation in the standardized screening process has increased my understanding about sexually reactive children.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 4 = 0 = 2 = 0 = 0

The second projected outcome was that investigating caseworkers would be able to provide a more comprehensive assessment of sexually reactive children. It was proposed that this outcome would be achieved by devoting two regular

investigation staff meetings to the topic of assessing sexually reactive children. At the first meeting the investigating staff realized that they did not have the academic basis to develop a comprehensive assessment plan. A consultant was contracted to provide a day long work session that addressed assessment of sexually reactive children.

Twenty-two agency personnel attended this work session. Caseworkers who were in a position to assess children were asked to complete the Risk Assessment Evaluation (see Appendix C). This included Child Protection investigators, ongoing caseworkers, adolescent workers who sometimes are required to make assessment of all members of a family, and placement workers. Administrators, case aides and other workers who attended the work session but who do not provide child assessments were asked to evaluate the work session but not to complete the Risk Assessment Evaluation. Fifteen staff members participated in the Risk Assessment Evaluation.

For the second outcome of this practicum to be considered successfully met 80% of the participating caseworkers must have strongly or mildly agreed with the four evaluation statements. In addition, 80% of the participants would be able to identify three elements that should be considered in assessing risks. At least 80% of the participants would be able to identify three factors to consider when evaluating

sexually reactive children. Table 2 displays the responses on the Risk Assessment Evaluation.

Table 2

Risk Assessment Evaluation Results

STATEMENT	RESPONSES	NO.
1. Participation in the risk assessment and evaluation work sessions gave me a better understanding of the issues of the sexually reactive child.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 6 = 8 = 1 = 0 = 0
2. I will now be able to do a more comprehensive evaluation of sexually reactive children.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 7 = 5 = 3 = 0 = 0
3. I will now be able to complete a more comprehensive risk assessment on sexually reactive children.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 5 = 6 = 3 = 1 = 0
4. Information shared at this work session will help to provide more consistent services to sexually reactive children.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 4 = 7 = 2 = 1 = 1

Thirteen workers responded to the opened ended questions on the evaluation form. All thirteen caseworkers were able to identify three components that should be considered in assessing risk. Nine components were suggested. Table 3 lists these responses in ranking order.

Table 3

Components to Consider in Risk Assessment

COMPONENT	NO. OF RESPONSES
CONSENT/COERCION	8
BEHAVIOR	7
EQUALITY	6
REPETITIVE BEHAVIORS	5
FAMILY'S SEXUAL NORMS	4
PREVIOUS SEXUAL VICTIMIZATION	3
CHILD' ABILITY TO EMPATHIZE	3
CHILD'S PERCEPTION OF BEHAVIORS	2
CHILD'S AFFECT	1

Thirteen caseworkers were able to identify three factors to be considered when conducting an evaluation on a sexually reactive child. Table 4 lists the responses in ranking order.

Table 4

Factors in an Evaluation

FACTORS	NO. OF RESPONSES
TYPES OF BEHAVIOR	8
PRESENCE OF AGGRESSION	7
CONSENT	5
HOME ENVIRONMENT	5
REPETITIVE BEHAVIORS	3
DISTORTED THINKING PATTERNS	3
EQUALITY	3
EMPATHY	2
COMMUNICATION	2
ACCOUNTABILITY	1

The third outcome proposed that Child Protection caseworkers would develop an increased awareness of treatment issues and options. The writer conducted a survey of community resources. Information about organizations that served sexually reactive children was compiled into a Treatment Options List (see Appendix H). This list was distributed to twenty caseworkers throughout the agency. These caseworkers were asked to review the Treatment Options List and complete the Treatment Options Evaluation (see Appendix D). For this outcome to be considered successfully met 80% of the participating caseworkers must have strongly or mildly agreed with the four evaluation statements. Sixteen caseworkers completed the Treatment Options Evaluation. Caseworkers had the option to rate these statements on a 1 to 5 scale. No one indicated that they mildly or strongly disagreed with these statements. Table 5 displays the responses to the Treatment Options Evaluation.

Table 5

Treatment Options Evaluation Results

STATEMENT	RESPONSES	NO.
1. The Treatment Options List is clearly written.	strongly agree =	12
	mildly agree =	4
	no opinion =	0
	mildly disagree =	0
	strongly disagree=	0
2. The Treatment Options List will be a useful tool in my work with sexually reactive children.	strongly agree =	10
	mildly agree =	4
	no opinion =	2
	mildly disagree =	0
	strongly disagree=	0
3. The Treatment Options List has increased my understanding of treatment issues and options.	strongly agree =	10
	mildly agree =	4
	no opinion =	2
	mildly disagree =	0
	strongly disagree=	0
4. The dissemination of the Treatment Options List will help provide more consistent services to sexually reactive children.	strongly agree =	8
	mildly agree =	8
	no opinion =	0
	mildly disagree =	0
	strongly disagree=	0

The fourth expected outcome was that foster parents who accept sexually reactive children will have an increased awareness of safety issues and their role in the treatment process. In order to achieve this outcome all licensed foster parents were invited to a work session that addressed the issues of sexually reactive children. Foster parents were sent a flyer and invited through their newsletter. The foster care coordinator phoned foster parents who catered to children under the age of ten and personally invited them to the work session.

Nine foster parents attended the work session. At the completion of this session foster parents were asked to complete the Foster Parent Program Evaluation (see Appendix E). Eight foster parents filled out this form. For this outcome to be judged successfully met 80% of the participating foster parents would strongly or mildly agree with the four evaluation statements. Table 6 denotes foster parent responses to the Foster Parent Program Evaluation.

Table 6

Foster Parent Program Evaluation Results

STATEMENT	RESPONSES	NO.
1. Participation in this program has given me a better understanding of the issues surrounding sexually reactive children.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 6 = 2 = 0 = 0 = 0
2. I will be willing to use this information to help children in my home who display sexually reactive behaviors.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 6 = 2 = 0 = 0 = 0
3. I enjoyed the presentation and format of this program.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 2 = 5 = 1 = 0 = 0
4. I believe that participation in this program will help to provide more consistent services to children who display sexually reactive behaviors.	strongly agree mildly agree no opinion mildly disagree strongly disagree	= 4 = 3 = 1 = 0 = 0

For this outcome to be judged successfully met, 80% of the participants would be able to identify three safety issues and three precautions. All responding foster parents were able to identify three safety issues to be considered before accepting sexually reactive children. Table 7 lists the safety issues that foster parents identified as factors to be considered before accepting a sexually reactive child.

Table 7

Identified Safety Issues

FOSTER PARENT RESPONSE	NUMBER OF TIMES INDICATED
TAKE INTO ACCOUNT HISTORY OF CHILDREN ALREADY IN HOME	7
UNDERSTAND NEEDS OF PERPETRATING CHILD	5
LEARN MORE ABOUT SEXUALLY REACTIVE CHILDREN	4
DEFINE PHYSICAL BOUNDARIES	3
DON'T USE PHYSICAL DISCIPLINE	2
DON'T LEAVE CHILDREN UNSUPERVISED	1
DON'T ACCEPT SEXUALLY REACTIVE CHILDREN	1
HELP CHILDREN ACCEPT NEW CHILD	1

Seven foster parents were able to identify three precautions to minimize risk. One foster parent was able to identify two precautions. Table 8 lists the suggested precautions to minimize risk.

Table 8

Identified Precautions to Minimize Risk

FOSTER PARENTS RESPONSE	NUMBER OF TIMES INDICATED
MAINTAIN CLOSE CONTACT WITH CASEWORKER	5
PREPARE FAMILY FOR ANTICIPATED PROBLEMS	4
GET MORE INFORMATION BEFORE ACCEPTING CHILDREN	4
NO SECRETS	2
ONLY ONE CHILD IN THE BATHROOM AT A TIME	2
LEARN MORE ABOUT SEXUALLY REACTIVE CHILDREN	2
PROVIDE A PSYCHOLOGICALLY SAFE ENVIRONMENT	1
HAVE A SUPPORT GROUP	1
NO PHYSICAL CONTACT	1
MY HUSBAND WILL NEVER BE ALONE WITH A FOSTER CHILD	1

While an objective criteria was not developed to analyze the results of the structured interviews, discussion of their results is necessary in order to understand the scope of this project. Community professionals from five disciplines were asked to review the *Sexually Reactive Children and Child Protection Services Manual*. This manual is a collection of the by-products of this practicum. It contains the recommendations of the Sexually Reactive Children's Panel, two literature reviews, the Screening Assessment, the Treatment Options List, a training outline for foster parents and a reference list.

The structured interviews lasted about an hour. Each professional was asked for their general impression of the manual. All were queried concerning the manual's usefulness in their professional setting. Interviews focused on how services

to sexually reactive children could be improved within this community. All reviews were extremely positive.

The mental health therapist appreciated the bibliography because it was current and complete. The therapist felt that the manual could be used to stimulate people from many disciplines to focus on the problems of sexually reactive children. The therapist commented that the manual was a concise overview. Child Protection is the first phase in the continuum of services for sexually reactive children. Other community professionals who make referrals to Child Protection may not have a clear understanding of the Child Protection piece of the continuum. The therapist believed that this manual could be used as a public relations tool to help community professionals better understand Child Protection's role, particularly in the screening process. This therapist stated that the foster parent training outline could have been more detailed. The therapist strongly advocated that all future training of staff should be conducted in an interdisciplinary fashion. All community professionals on the continuum of services should have a shared knowledge base.

The medical professional felt that the manual's strongest feature was the sequence of the layout. This professional felt that enough research and background information was presented to develop a plan of action. A plan to restructure services in order for sexually reactive children to receive a

higher priority should be presented to the county commissioners.

Child sexual abuse is a topic that is now covered in most medical schools. However, it is not covered to the extent that physicians feel comfortable identifying, treating and referring sexually reactive children. The medical representative suggested that Child Protection personnel should petition medical schools to require that all Family Practice medical students complete a residency placement through the Kempe Center. Child sexual abuse is time consuming to diagnose because it involves consultation with medical and non-medical professionals who do not share a common knowledge base. There is no standardized medical model for diagnosing sexually reactive behaviors. This medical professional stated that the Screening Assessment was a start in the process of developing a model of intervention with sexually reactive children.

The Early Childhood Specialist reviewed the manual from the perspective of individual cases. This manual will be used as a basis for team training and as an aid in case planning in the developmental preschool. The specialist described the manual as a linkage tool between the two disciplines, Child Development and Child Protection. The manual provides a common knowledge base and impugns some myths about sexual behaviors in children. Early Childhood professionals are aware of normal

sexual behaviors in children. They know the difference between normal and deviant behaviors. They base their knowledge on "gut feelings." The manual validates and gives a language to these feelings.

The attorney would have liked to have seen more solutions presented. In this community the Juvenile Justice system is overwhelmed. There are not enough treatment resources or residential placements for offending teenagers. The Screening Assessment will help identify children predisposed to the Juvenile Justice system. The attorney noted that the Community Options List was an excellent resource for early interventions. Identification and treatment of sexually reactive children appears to be an expensive undertaking. However, if services to sexually reactive children could be viewed as a diversion from the Juvenile Justice system, this would be human resource dollars well-invested.

The elementary school principal expressed a desire to share the manual with the school team. The manual will be used to help teachers know what to look for and how to provide support to sexually reactive children. Although some teachers still have mixed feeling about becoming involved in the personal problems of students, this principal understood that school personnel cannot be uninvolved. Teachers are obligated by law to report suspected child abuse. The manual presents a clear direction about which behaviors should be reported. In

progressive schools teachers work with mental health therapists as members of a treatment team to provide daily support to the student. The school usually is in the position to provide support to the parent also.

Child Protection appears to be a frightening system to both teachers and parents. Confidentiality policies are partly to blame for these fears. Teachers do not receive feedback from caseworkers about referrals. In most cases if the teacher receives any feedback at all it is from an angry parent. This principal felt that sharing this manual with teachers may be the first step in establishing an understanding of the Child Protection system.

Sexually overt behaviors in elementary school children are becoming more prevalent. Therefore, it is essential that elementary school teachers understand childhood sexuality. Teachers play a major role in identifying and referring victims of sexual abuse. Teachers now have a greater challenge with sexually reactive children. Teachers must provide a positive environment for the sexually reactive child and protect all the children in the classroom. Teachers need more information. They must learn about the dynamics of sexually reactive children in general and they must have specific information about sexually reactive children in their classroom.

In the eight month implementation period of this practicum Child Protection received 35 referrals concerning sexually reactive behaviors in children under the age of ten. Eighty- six children were involved. Allegations ranged from touching private areas to vaginal and anal penetration. Table 9 analyzes this data according to age and sex.

Table 9

Age and Sex of Referred Children

AGE	MALES	FEMALES	TOTAL
10	2	3	5
9	3	2	5
8	5	4	9
7	5	3	8
6	11	10	21
5	6	10	16
4	7	4	11
3	1	4	5
2	2	3	5
6mo.	1	0	1
TOTAL	43	43	86

Ryan (1993) categorized childhood sexual behaviors on a four step continuum from normal sex play to dangerous behaviors. Normal behaviors are of an exploratory or game-like nature. They include occasional masturbation, exposing games, flirting, kissing and playing doctor. Children in the yellow flag range have precocious sexual knowledge and a preoccupation with sex. This is manifested in behaviors such as mutual masturbation, single episodes of peeping, exposing

or frottage, simulating foreplay with clothes on or attempts to expose others. Children in the red flag area appear to have a sexual compulsion. They exhibit repeated or chronic sexual behaviors. They attempt to touch the genitals of others, engage in compulsive masturbation which could include penetration with an object, sexually degrade others and continue sexual activities such as peeping, exposing and frottage when admonished to stop. Black flag or perpetrating behaviors include oral, vaginal or anal penetration, beastality, forced touching of others and simulated intercourse with clothes off.

The 35 referrals received during this implementation period were analyzed according to type of behaviors and sex and age of alleged perpetrator. Table 10 displays this analysis.

Table 10

Continuum of Reported Behaviors

AGE	NORMAL		YELLOW FLAG		RED FLAG		BLACK FLAG		TOTAL	
	boy	girl	boy	girl	boy	girl	boy	girl	boy	girl
10	0	0	0	1	0	0	1	1	1	2
9	0	0	0	1	0	1	1	0	1	2
8	0	0	2	1	2	1	1	1	5	3
7	0	0	1	0	0	2	1	0	2	2
6	0	0	1	1	0	2	1	0	2	3
5	0	0	0	3	1	0	3	0	4	3
4	0	0	1	1	1	0	1	0	3	1
3	0	1	0	0	0	0	0	0	0	1
TOTAL	0	1	5	8	4	6	9	2	18	17

Discussion

The goal of this practicum was to improve Child Protection Services to sexually reactive children. Four outcomes effecting different units of the service delivery system were expected. The first expected outcome was that workers who receive referrals alleging sexual activity between children would be able to determine if the behaviors were in a normal developmental range or if further assessment was warranted. A Screening Assessment was developed. Screeners were asked to review the Screening Assessment and complete the Standardized Screening Evaluation.

Two of the four screening evaluation statements were not rated high enough for the screening outcome to be considered successfully met by the pre-set criteria (see Table 1). This could be attributed to the fact that more than half of the Child Protection staff left the unit during the practicum implementation period. Only six staff were available to complete the evaluation. The low number of screeners meant that if only one screener did not strongly or mildly agree with an evaluation statement the outcome would not be deemed successful. Two screeners indicated that they had no opinion regarding the explanation and processes of the standardized screening criteria because they were new workers who did not participate in the developmental stage.

A more accurate evaluation of the standardized screening outcome might be the response of the Child Sexual Perpetrators Work Group to the Screening Assessment. This group, composed of Child Protection personnel from fifteen counties, agreed that the Screening Assessment accurately and concisely clarified Child Protection's response to allegations of sexual behaviors between children. This group recommended that the Screening Assessment be adopted for statewide use. Thus, the Screening Assessment that was developed to satisfy the first outcome requirement of this practicum, has been recommended by the State Department of Social Services for use in all counties to standardize Child Protection response to allegations of sexually reactive behavior in children under ten.

The second outcome of this practicum projected that investigating caseworkers would be able to provide a more comprehensive assessment of sexually reactive children. Through the Sexually Reactive Children's Panel the writer discovered that staff in units other than investigation are called upon to make assessments and evaluate risks of behavior in sexually reactive children. For this reason caseworkers throughout the department who had an interest in upgrading their assessment skills were invited to participate in a work session. Fifteen caseworkers attended the work session and completed the Risk Assessment Evaluation.

The Risk Assessment Evaluation results indicate that after the work session thirteen caseworkers, or 86% of the participants, were able to identify three components to be considered in assessing risk (see Table 3) and three factors to be considered when conducting an evaluation (see Table 4). This outcome would have been deemed successful if 80% of the participating caseworkers could identify three components and three factors.

Statements one and two on the Risk Assessment Evaluation met the requirements for a successful outcome (see Table 2). Statements three and four were not agreed with to the level necessary for this outcome to be considered successfully met.

Caseworkers who participated in the work session were able to identify components in a risk assessment and factors in an evaluation. However, a standardized risk assessment or evaluation scale was not developed. Developing these scales was not within the scope of this project. The writer speculates that caseworkers rated low their ability to conduct a comprehensive risk assessment and the success of the work session in providing more comprehensive services because standardized tools were not presented or developed.

The development of a standardized risk assessment or criteria for evaluation would be an important contribution to the field of Child Protection. These scales or tools would

have to be grounded in research theory and each element in the scales or tools would need to be field tested for validity.

While participation in the work session clarified for caseworkers what components should be assessed, the problem of how to interview a young perpetrator was not resolved. Lack of validated assessment tools, absence of guidelines for conducting a young perpetrator interview and the need for clarification surrounding the caseworker's authority to interview a young perpetrator are assessment issues that cannot be resolved at the local level. However, through the efforts of this practicum, these concerns were raised at the local level and brought to the attention of administrators at the State level. The State Department os Social Services' legal advisors are addressing the question of caseworker authority. Department personnel are studying the problems related to caseworker training and perpetrator assessments.

The work of this practicum in the area of assessment has had effects beyond the local level. The Sexually Reactive Children's Panel's definition of young perpetrator has been accepted as the criteria to be used by all counties for confirming a young perpetrator on the Central Registry.

The third outcome, Child Protection caseworkers will develop an increased awareness of treatment issues and options, was successfully met according to pre-established criteria (see Table 5).

A survey of community resources revealed that twelve centers or individuals are willing to provide assessment and counseling to sexually reactive children under the age of ten. Many of these therapists stated that they accept insurance. Sliding scales fees for low income, uninsured families start at twenty-five dollars an hour. Esterl and Pagano (1992) found that successful treatment for sexually reactive children is a slow process that is rarely completed in less than a year.

Kahn (1990) and MacFarlane and Cunningham (1988) support group therapy as the most effective modality for treating sexually reactive children. Group therapy is recommended because of the interpersonal nature of the problem. Children can identify with the shame, fear and guilt of other sexually reactive children. Knowing that they are not the only child with this problem can help overcome the feeling of isolation. Children can help each other recognize denial and minimization. There is only one facility in this community that offers group therapy for young sexually reactive boys. There are no groups for young girls.

Data on social-economic status was not compiled on the referrals during the implementation period. However, in this period the writer investigated nine cases where counseling for sexually reactive behavior was recommended but was unattainable because of lack of financial resources on the

part of the family. The writer brought this to the attention of the Sexually Reactive Children's Panel.

Seventeen of the 35 referrals received (see Table 10) identified a female as the aggressor. Eight girls out of this group of seventeen were exhibiting behaviors in the red or black flag categories. The community survey and data collected from referrals indicate that there is a gap in the service continuum at the treatment level for low income sexually reactive children, especially females. The Department's family therapist, who served on the Sexually Reactive Children's Panel, has made a commitment to develop a mixed-gender treatment group for low income sexually reactive children.

All criteria was met to conclude that the fourth outcome was achieved (see Table 6). That is, foster parents who accept sexually reactive children will have an increased awareness of safety issues and their role in the treatment process.

The writer had concerns about the responses of one foster parent. This foster parent identified a way to keep the family safe as not to accept sexually reactive children. A way to minimize risk was not to allow the husband alone with the foster child. These were not messages conveyed in the work session. People who work with or care for sexually abused and sexually reactive children need a higher level of training and commitment than people who tend children who are not struggling with sexual issues. It is unfair to both the foster

parents and the foster child to make a placement in an unprepared home. Gil (1987) found that young offender treatment is rarely successful unless the primary caretaker is invested in the treatment process. People who choose to foster sexually abused or sexually reactive children must be viewed as members of the treatment team. As a team member foster parents must have a basic understanding of the dynamics of sexually abused and sexually reactive children. Foster parents must also have specific information about the children they are parenting. This agency, through the undertaking of the Sexually Reactive Children's Panel, has become more sensitive to training and support issues of foster parents. A second presentation of the training curriculum for foster parents willing to care for sexually reactive children is scheduled to take place in October.

The feedback concerning the *Sexually Reactive Children and Child Protection Services Manual*, on an informal level by agency staff and on a more formalized level by community professionals through the structured interviews, was extremely positive. Each community professional expressed that the manual provided a shared knowledge base grounded in academic research. While Child Protection has a legal responsibility to serve sexually reactive children, they do not have sole responsibility. Krivacska (1991) expressed dismay that sex education for young children is based on Child Protection

principles rather than Child Development models. Young children are taught that sexuality is bad, private or inappropriate rather than that sexuality is a natural part of the human growth cycle. School and preschool personnel must be educated to the fact that children are sexual beings who are curious about all aspects of life. School personnel must be taught to recognize the difference between sexuality and sexual abuse.

About one third of Child Protection referrals are initiated by school or preschool personnel. The interviews with the Early Childhood Specialist and the elementary school principal reinforced the concept that the continuum of care for sexually reactive children does not begin with Child Protection and end with Mental Health services. The continuum begins with the school or preschool personnel who observe and react to the behaviors. Personnel who ignore, deny or minimize behaviors because of lack of training miss an opportunity to provide early intervention.

In most cases children and families are involved in the Child Protection and Mental Health systems for limited periods of time. Schools are involved with these children and their families for a twelve year period. Schools are in a position to help sexually reactive children by setting boundaries and modeling and reinforcing appropriate social behaviors. Information about individual children must be shared with

school personnel. Confidentiality laws build barriers between agencies. Cantwell (1993) writes that the protection of children is a community prob em that will not be solved until agencies stop hiding behind confidentially laws and start working together. Children involved in the Child Protection system become mysterious because they have secret problems. Professionals must start talking together about the problems of children. People cannot work together if they cannot talk together.

Both the Early Childhood Specialist and the elementary school principal who reviewed the manual expressed a desire to share this handbook with their staff. Educators, mental health therapists, medical professionals and Child Protection caseworkers all share the same basic goals for sexually reactive children and their families. Each of these professionals has a unique and important role in the healing process. It is hoped that through the dissemination of this manual a shared knowledge base will contribute to more holistic services for sexually reactive children.

The lawyer for the District Attorney's office who reviewed the manual envisioned the identification and treatment of sexually reactive children as the starting point on the continuum of community services to prevent involvement with the juvenile justice system. Early identification and appropriate and adequate treatment for these children now

should be viewed as a community investment that will save mental health and criminal justice dollars in the future. This is made evident by reviewing the progress of Rose whose case scenario was presented in Chapter II. Four months after Rose *(case b)* discontinued individual therapy she attempted suicide again. In the hospital she disclosed that she had re-victimized her brother and molested another younger child. Her brother is displaying sexually reactive behaviors. The new victim is exhibiting emotional problems that will require therapy. The cost of appropriate treatment for Rose, group and family therapy, would be cheaper then the cost of treatment for Rose's new victims and their families. When Rose's perpetrating behaviors were first discovered there was no group in this community that would accept Rose because she was uninsured and a female. Rose has been accepted into the Department's newly developed young perpetrators group. In order to be allowed to continue in this group her parents must participate in family therapy. If this treatment is successful, Rose may not become involved in the criminal justice system.

The tracking of referrals through the eight month implementation period confirms the suspicion that sexually abusive behaviors between young children is not a rare occurrence. Lamb and Coakley (1993) found that children are more likely to disclose sexual abuse that is committed by an

adult that abuse committed by another child. They hypothesize that children are less likely to disclose abuse by another child because children may be unsure if the experience was abusive or they may be unclear about their culpability. Lamb and Coakley suggest that only about 14% of sexual abuse incidents between children are reported.

In this community in an eight month period there were 35 reports of inappropriate sexual play among children. Eighty-six children were involved (see Table 9). Twenty-one referrals alleged behaviors in the red or black flag areas (see Table 10). It is hoped that the accurate documentation of these referrals will be used to support an expansion of services to sexually reactive children.

The fact that State Central Registry personnel have become alarmed about the increased numbers of child perpetrators indicated that this problem is not unique to this county. The Child Sexual Perpetrator Work Group met four times. This group voiced concerns similar to those raised by the local Sexually Reactive Children's Panel. The work of the Sexually Reactive Children's Panel contributed to the accomplishments of the state Work Group. The Child Sexual Perpetrators Work Group helped to standardized Child Protection Practice throughout the state by: 1. defining behaviors between children that will trigger a Child Protection investigation; 2. setting criteria for confirming

young children as sexual perpetrators on the Central Registry; 3. recommending extended expungement rights for young perpetrators listed on the Central Registry; 4. conveying local concerns about gaps in the Child Protection system to State Department of Social Services personnel.

Perhaps the most important contribution of the practicum implementation was that in the midst of organizational chaos, staff with diverse agency roles were able to develop improved standards of services based on academic research and field work. The practicum process served as a uniting factor that empowered front line staff to make agency policy and changes to improve services to sexually reactive children.

Recommendations

1. Child Protection Services is in a unique position to document and analyze the sociological dynamics of families. The information that caseworkers witness and report is the raw data that researchers use to build academic theory. In turn this theory is used to build models of practice and treatment. Sexually reactive behavior in young children is a problem that is new to the academic and research arena. It is vital that Child Protection workers investigate and document cases not only to protect children but also to contribute to the field of knowledge of Child Development, Child Protection and Sociology.

2. Child Protection practice should be grounded in academic research and field work. There should be committees based on the model of the Sexually Reactive Children's Panel to study various aspects and issues of Child Protection with the end goal of improving services and standardizing practices.
3. The administration should study the recommendations of the Sexually Reactive Children's Panel and produce a written response to each suggestion.
4. All caseworkers and foster parents should receive training specific to the issues of sexually reactive children. No caseworker or foster parent should be assigned to work with a sexually reactive child until proper training is completed.
5. Sexually reactive children live and learn in the community. Information about these children should be shared with people who are in a position to care for or treat these children. Both case specific information and academic and theoretical information should be available to community professionals.
6. Research must continue in the field of Child Protection, especially in the area of sexually reactive children. Standardized tools must be developed to evaluate these children.
7. All sexually abused children and sexually reactive children should be afforded treatment which is based on their individual needs determined by a comprehensive assessment.

Dissemination

Many parts of this practicum have already been disseminated throughout this agency, the community, other county Departments of Social Services and the State Department of Social Services. The Screening Assessment and definition of a young perpetrator have been sent to all county Departments of Social Services by the State Department of Social Services.

One hundred copies of *Sexually Reactive Children and Child Protection Services* have been distributed. Each caseworker and administrator in the local agency received a copy. Each member of the Child Protection Team was given a copy of the manual. Each member of the Child Sexual Perpetrators Work Group received a manual. The writer received requests for copies of the manual from local community professionals and caseworkers from other counties. The writer is aware of three training sessions where materials from the manual will be presented.

The writer is in the process of preparing a paper to submit to a professional journal. The paper, based on part of the literature review and data collected during the implementation period, will be a case review of female sexually reactive children.

Finally, copies of the completed practicum report will be given to each member of the Sexually Reactive Children's Panel. Copies of the report will be presented to the State

Department of Social Services, Kempe Center and local Department of Social Services' libraries.

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APPENDIX A

PRELIMINARY CASEWORKER SURVEY

To: Child Protection Workers

From: Pat Verstraete

Re: Child perpetrators

Date: 9-1-92

I am hoping to do my second doctoral practicum on children under the age of 10 who molest other children. Right now I am in the formation stage and need some data about this population. Please fill out this questionnaire on any child on your caseload who has molested another child in 1992. If you are in intake and know of any cases that were I&R'ed please call them to my attention. Also, I would like to be informed of any new reports of this problem from now on. Thanks, Pat

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Name	Age	sex	age & sex of victim	type of DSS intervention

APPENDIX B

STANDARDIZED SCREENING EVALUATION

STANDARDIZED SCREENING EVALUATION

Please answer the following statements by circling the response that best describes your feelings. Please feel free to make any comments on the reverse side. Thank you.

5 = strongly agree
4 = mildly agree
3 = no opinion
2 = mildly disagree
1 = strongly disagree

---

1. Use of the standardized criteria for screening allegations concerning sexually reactive children was clearly explained.	5 4 3 2 1
2. I am willing to use this criteria for screening calls.	5 4 3 2 1
3. I believe that this screening criteria will help to provide more consistent services to sexually reactive children.	5 4 3 2 1
4. Participation in the standardized screening process has increased my understanding about sexually reactive children.	5 4 3 2 1

Suggestions for improving the standardized screening criteria:

APPENDIX C

RISK ASSESSMENT EVALUATION

RISK ASSESSMENT EVALUATION

Please answer the following statements by circling the response that best describes your feelings. Please feel free to make comments on the reverse side about this project or information presented. Thank you.

5 = strongly agree
4 = mildly agree
3 = no opinion
2 = mildly disagree
1 = strongly disagree

---

1. Participation in the risk assessment and evaluation work sessions gave me a better understanding of issues surrounding the sexually reactive child.	5 4 3 4 1
2. I will now be able to do a more comprehensive evaluation of sexually reactive children.	5 4 3 2 1
3. I will now be able to complete a more comprehensive risk assessment on sexually reactive children.	5 4 3 2 1
4. Information shared at these work sessions will help to provide more consistent services to sexually reactive children.	5 4 3 2 1

List three components that should be considered in assessing risk.

1.

2.

3.

List three factors that should be considered when conducting an evaluation of a sexually reactive child.

1.

2.

3.

APPENDIX D

TREATMENT OPTIONS EVALUATION

TREATMENT OPTIONS EVALUATION

Please answer the following statements by circling the response that best describes your feelings. Please feel free to make comments on the reverse side. Thank you.

5 = strongly agree
4 = mildly agree
3 = no opinion
2 = mildly disagree
1 = strongly disagree

---

1. The Treatment Options List is clearly written.	5 4 3 2 1
2. The Treatment Options List will be a useful tool in my work with sexually reactive children.	5 4 3 2 1
3. The Treatment Options List has increased my understanding of treatment issues and options.	5 4 3 2 1
4. The dissemination of the Treatment Options List will help provide more consistent services to sexually reactive children.	5 4 3 2 1

If you are aware of any treatment options that did not appear on this list, please identify them. If new resources are identified a revised Treatment Options List will be distributed.

APPENDIX E

FOSTER PARENT PROGRAM EVALUATION

FOSTER PARENT PROGRAM EVALUATION

Please answer the following statements by circling the response that best describes your feelings. Please feel free to make comments on the reverse side. Thank you.

5 = strongly agree
4 = mildly agree
3 = no opinion
2 = mildly disagree
1 = strongly disagree

---

1. Participation in this program has given me a better understanding of the issues surrounding sexually reactive children. 5 4 3 2 1

2. I will be willing to use this information to help children in my home who display sexually reactive behaviors. 5 4 3 2 1

3. I enjoyed the presentation and format of this program. 5 4 3 2 1

4. I believe that participation in this program will help to provide more consistent services to children who display sexually reactive behaviors. 5 4 3 2 1

5. Please identify 3 safety issues that a foster parent must consider before accepting a sexually reactive child.

1.

2.

3.

6. Please identify three precautions that you as a foster parent can take to minimize risks to yourself, your family or the sexually reactive child.

1.

2.

3.

APPENDIX F

RESOURCE SURVEY

BASIC INFORMATION:

NAME OF PROGRAM:

ADDRESS:

PHONE NUMBER:

CONTACT PERSON:

TYPES OF SERVICES PROVIDED TO SEXUALLY REACTIVE CHILDREN:

SERVICES	COST	INSURANCE ACCEPTED

ASSESSMENT

INDIVIDUAL COUNSELING

GROUP THERAPY

OTHER SERVICES

PLEASE EXPLAIN YOUR SERVICE MODALITIES, ASSESSMENT AND TREATMENT METHODS AND PROGRAM PHILOSOPHIES.

IF YOU PROVIDE GROUP THERAPY PLEASE LIST:

TARGET POPULATION OF GROUP TIME AND DAY OF GROUP

CRITERIA FOR ACCEPTANCE INTO YOUR PROGRAM:

IS THERE A WAITING LIST?
IF YES, HOW LONG?

STAFF INFORMATION:

IF THIS IS A RESIDENTIAL SERVICE WHAT IS THE STAFF/CHILD RATIO?

WHAT IS THE EDUCATIONAL REQUIREMENT FOR STAFF?

WHAT TYPE OF THERAPY IS AVAILABLE TO SEXUALLY REACTIVE CHILDREN?

IS THERAPY CONTRACTED OUT OR A PART OF RESIDENTIAL SERVICES?

WHAT SPECIAL PROGRAMS OR PRECAUTIONS ARE IN PLACE FOR SEXUALLY REACTIVE CHILDREN?

IF ASSESSMENT AND/OR THERAPY IS THE SERVICE PROVIDED, PLEASE LIST EDUCATIONAL AND EXPERIENCE REQUIREMENTS OF STAFF.

COMMENTS OR OTHER INFORMATION ABOUT YOUR SERVICES:

PLEASE MAIL SURVEY TO:
Pat Verstraete
Mesa County Dept. of Social Services
2952 North Ave.
Grand Junction, Co. 81502

APPENDIX G

SCREENING ASSESSMENT

SCREENING ASSESSMENT FOR REPORTED SEXUALLY REACTIVATE BEHAVIORS BETWEEN CHILDREN UNDER TEN.

BEHAVIORS:

Simulated intercourse - clothes on
Mutual masturbation
Touching or rubbing of genitals
Sex games
French kissing
Single incidents of exposing, voyeurism or frottage

RESPONSE:

Screener will ask referral source to monitor behavior. Screener may send referral source information on sexually reactive children.

BEHAVIORS:

Simulated intercourse - clothes off
Continued Sexual behavior when asked to stop
Repeated and/or a combination of incidents of exposing, frottage, attempting to expose others or voyeurism.
Forced touching of genitals
Oral/genital contact
Insertion of objects into the anus or vagina
Sexual intercourse
Use or threats of violence in sexual acts

RESPONSE:
Referral will be assigned to a caseworker for investigation.

Mesa County will consider a child under ten to be a perpetrator when:

1. There is an imbalance of power between children. This imbalance is not limited to age and size. Developmental level, status and circumstances will be considered.

2. There is force or lack of consent.

3. The act is sexual in nature and developmentally inappropriate.

4. Inappropriate sexual behavior is repetitive.

APPENDIX H

TREATMENT OPTIONS LIST

Alpha Center
640 Belford Ave.
241-2948

Provides assessments, individual counseling and family therapy. Cost is sliding scale starting at $25./hr. Accepts most insurance and state medicaid. Does not take HMO.

Each case is assessed for level of acting out, resources for change and level of cooperation. Treatment is focused on setting up behavioral and environmental controls and educating the care providers towards stopping the behavior in a proper way and replacing it with better/different behaviors.

All staff have Master's degrees or above plus extensive experience and supervision.

Saul Tompkins, Tammy Dunkin, John Mason, John Sorric

Behavior Health Center
1005 N. 12th #108
242-5707

Provides full psychological assessments to children and parent capacity assessments. $50.- 90./hr. Accepts most insurance including HMO.

Individual therapy is based on evaluation, goals are behavioral. Cognitive/behavioral model. Family therapy is brief, strategic systems.

All staff are licensed - Two Ph.d psychologist on staff. Other staff hold Masters degrees.

Chris Young, Cheryl Young, Pat Mills, Carolyn Hughs, Robert Fegal

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Mae Bossom
1231 Kennedy Ave.
242-3939

Assessment and Individual counseling. $70./hr. Some insurances accepted.

Can provide individual and play therapy to sexually reactive children. Believes children can take back their power lost in sexual abuse by expressing their aggressive energy.

Masters in counseling.

Center for Enriched Communication
496 28.5 Road
243-9539

Provides assessments and play therapy. Assessment are $40./hr. Counseling costs $25./hr. Some insurances accepted. There is usually a three month waiting list.

Will be starting adolescent offenders groups.
Staff holds Master's degrees.
Pat Lewter, Ulrike Magdalenski

Dan Doyle
1005 N.12th St., #206
245-1798

Provides psychological assessments of children under ten. Will provide therapy to boys. Can provide art and play therapy. Will accept Medicaid and some insurances. $60-80./hrs.

Ph.D. Licensed psychologist.

Family Counseling Center
2600 N. 12
245-6624

Provides assessments, individual therapy and family counseling. $50./hr. Some insurance accepted.
Focus is more on family problems and anger management.
Steven Landman - Licensed marriage and family therapist.

Hilltop
1331 Hermosa
243-4646
Provides assessments, individual counseling, group therapy and training to professionals about sexually reactive children. Accepts most insurance including HMO and Medicaid. $85./hr. individual therapy. $40./hr for group.

Uses assessment and treatment models from Redirecting Sexual Aggression. Treatment plan is developed from interview information and investigation reports. Treatment of choice for sexually reactive children is group. Children are taught to be accountable for their behaviors.

Group is held on Wed. from 4-5:30 for children 8-12 years old. There is no waiting list.
Nancy Tanner - MSW plus extensive training with Redirecting Sexual Aggression.

Todd Kemp
1129 Colorado Ave.
244-3834

Individual and family counseling. No insurance. Fees $25.-50./hr based on family income.

Uses brief therapy models. Integrates cognitive-behavioral theories with family systems and structural interventions.

Master's in counseling.

Gary Miller
Day House
838 Grand Ave.
242-9294

Family therapist for the Department. Will provide services to children with perpetrating behaviors that are at risk for out of home placement. Sliding scale fee.

Perpetration issues are addressed within the context of the family.

Licensed MSW

Janet Mullins
2232 N. 7th #16
241-5914

Psychological assessments, family assessments, individual and family therapy. Accepts HMO and some insurances. $90./hr.

Strong background in early childhood development. Specializes in working with preschool victims of sexual abuse.

Ph.D in Psychology

Sue Polan
Western Colorado Pediatric Associates
2323 N. 7th
243- 5437

Assessment and therapy for young children. Takes a limited number of HMO clients

Specializes in working with preschool victims of sexual abuse.

MA, LPC

Psych Health
2004 N. 12th
241-6500

Provides psychiatric evaluations, assessments and individual counseling. Fees range from $68-110./hr. Some insurances accepted.

The modality of choice is non-directive play therapy. Parents are involved in learning behavior modification. Cognitive therapy in which choices and rational reasoning are utilized, reinterpreted and reframed for and with the child, is used. Psych Health has an array of services for the ADD child.

An MD licensed psychiatrist provides clinical supervision to staff. Staff has Master's degrees or above.

Carolyn Nelson-Sanda, Judy Lauer, Jim Lauer

RESIDENTIAL OR INPATIENT RESOURCES

Mt. St. Vincent's Home
4159 Lowell Blvd.
Denver, Co. 80211
458-7220

Residential placement for boys and girls ages 5 to 12. Provides residential treatment, day treatment and after care. There is a child offender's group on campus.

Therapists are Master's level and licensed. Mental health workers are B.A. level.

Cleo Wallace Center
Box 345
Bloomfield, Co. 80038
466-7391

Inpatient evaluations

Centennial Peaks Hospital
2255 South 88th Street
Louisville, Co. 80027
673-9990

Inpatient evaluations

RESOURCES FOR CONSULTATION AND PROFESSIONAL TRAINING

Kempe Center
1205 Oneida
Denver, Co. 80220
321-3963

Redirecting Sexual Aggression
1410 Vance Street, Suite 107
Lakewood, Co. 80215
232-5749

APPENDIX I

FOSTER PARENT TRAINING OUTLINE

TRAINING OUTLINE FOR FOSTER PARENTS WILLING TO CARE FOR SEXUALLY REACTIVE CHILDREN.

GOAL: To create a safe home environment that will support the therapeutic goals of sexually reactive children.

PART I - Understanding Sexuality

GOAL: To help foster parents become more sensitive to their feelings and values surrounding sexual issues.

A. Acknowledge that adults learn about sex in a variety of questionable ways.

B. Describe the different words used for penis, vagina and intercourse.

C. Discuss comfort level with these words.

D. Talk about children as sexual beings.
   1. Discuss normal sexual development in children.
   2. Describe questions children may have about sexuality and discuss how foster parents should answer these questions.

E. Discuss personal feelings and beliefs about sexuality and how these may come in conflict with a foster child's background.
   1. Homosexuality
      A. Children may have homosexual parents, siblings or friends.
      B. Child may have had homosexual experience.
      C. Child may have been molested by a same-sex person.
      D. Child may be experiencing conflict about sexual orientation.
   2. Values
      A. Sex and Marriage - Child may have been born out of wedlock.
      B. Families - Functions and compositions of families. Roles of family members.
      C. Family secrets vs. privacy.
   3. Other issues
      A. AIDS and sexually transmitted diseases
      B. Foster parent as sex educator.

Make time for questions and discussion.

PART II: The Sexually Abused Child

GOAL: To raise the comfort and confidence level of foster parents who provide care for sexually abused/sexually reactive children.

A. Develop a definition of what is sexual abuse.
   1. legal definition
   2. therapeutic definition
   3. community standard and response to sexual abuse

B. Explain the dynamics of incestuous family.

C. Review dynamics of sexual abuse.
   1. Sense of betrayal
   2. Powerlessness
   3. Guilt and shame
   4. Sexualization

D. Discuss feeling surrounding sexual abuse.
   1. Child's feelings towards perpetrator, other family members and the system
   2. Foster parent's feelings toward child, perpetrator, non-protecting parent, the system

E. Talk about behaviors of the sexually abused child.
   1. Anger driven
   2. Depression
   3. Confusion - inconsistent behaviors
   4. PTSD
   5. Effects of behaviors on parents, other children

F. Examine system response to sexual abuse.
   1. Investigation
   2. Court
   3. Therapy
   4. Role of foster parent

G. Brainstorm how to help the child.
   1. Role play welcoming child to home
   2. How to communicate with the child
   3. What to communicate to caseworker and therapist
   4. Whole life experience
   5. Discipline - consistency, structure and stability, supervision, self-esteem building, positive guidance

Make time for questions and discussion.

PART III - The Sexually Reactive Child

GOAL: To teach foster parents ways to help the sexually reactive child develop empathy and accountability.

A. Review Ryan's continuum of sexual behaviors.

B. Discuss how to respond to sexually reactive behaviors.

C. Role play how to respond to sexually reactive behaviors.

D. Explain the cycle of abuse.

E. Talk about cognitive distortions, defense mechanisms.

F. Review how defense mechanisms are survival skills. Relate this to behaviors.

G. Discuss how to make home more safe
   1. Protection of other children
   2. Sexual behaviors toward the foster parents
   3. Higher level of supervision
   4. Bathroom/bedroom rules

H. Examine the healing process.
   1. Appropriate discipline
   2. Positive sexuality
   3. An environment of psychological safety

Make time for questions and discussion.