Let's Talk About Touching

Creating Treatment Interventions for Children with Concerning Sexualized Behaviour - 1st Edition

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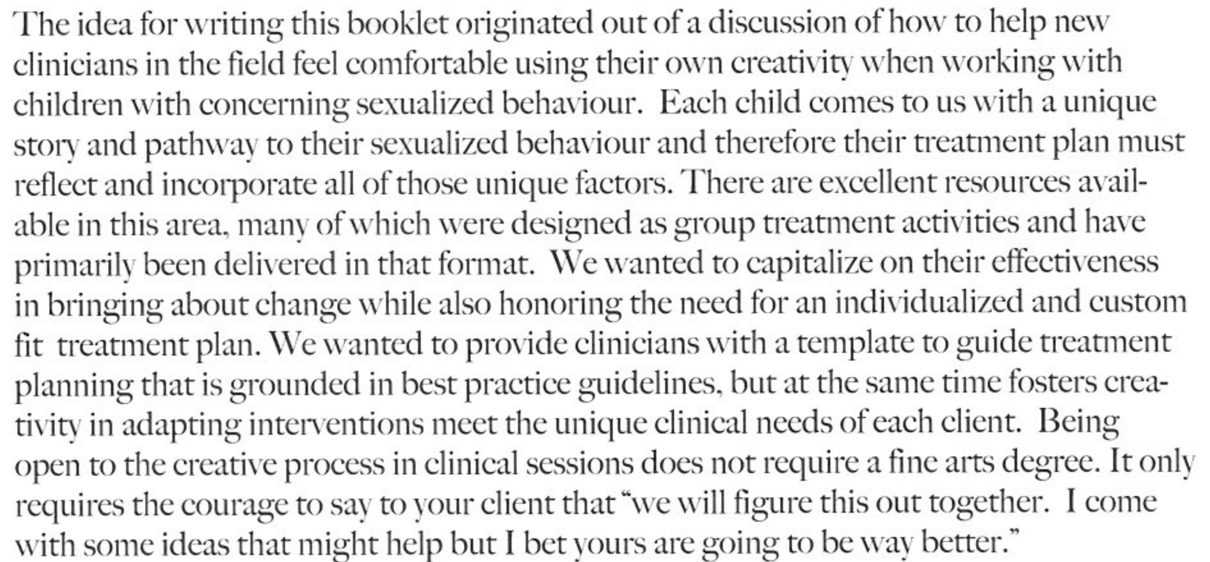
INTRODUCTION



The idea for writing this booklet originated out of a discussion of how to help new clinicians in the field feel comfortable using their own creativity when working with children with concerning sexualized behaviour. Each child comes to us with a unique story and pathway to their sexualized behaviour and therefore their treatment plan must reflect and incorporate all of those unique factors. There are excellent resources available in this area, many of which were designed as group treatment activities and have primarily been delivered in that format. We wanted to capitalize on their effectiveness in bringing about change while also honoring the need for an individualized and custom fit treatment plan. We wanted to provide clinicians with a template to guide treatment planning that is grounded in best practice guidelines, but at the same time fosters creativity in adapting interventions meet the unique clinical needs of each client. Being open to the creative process in clinical sessions does not require a fine arts degree. It only requires the courage to say to your client that "we will figure this out together. I come with some ideas that might help but I bet yours are going to be way better."

We have organized this booklet into a number of sections. Each section builds on information from the previous section, and culminates in the use of a worksheet that will assist the reader in a) incorporating the research and best practice guidelines when creating an intervention. b) ensuring that they are reflecting holistically on the child and their family's unique treatment objectives and c) organizing their treatment objectives into a comprehensive treatment plan.

The sections are short, and the information included in each is based primarily on clinical practice with the foundational support of the most current research available to us. They are by no means exhaustive, but complimentary to a foundational knowledge and contribute to the framework one can utilize when providing treatment with this population.

Tenets of treatment, from our perspective, are those elements that have achieved a level of professional consensus. While theoretical paradigms and therapeutic approaches to treating children who exhibit concerning sexualized behaviours may differ between treatment providers, both the literature and collective wisdom share these common tenets.

Evidenced Based

As the field of concerning sexualized behaviour treatment continues to progress we are reminded and often humbled by the pace of sound scientific inquiry. While most assuredly time will demonstrate new advancements that as yet have not been considered, we must adhere to our best evidence to date. Acknowledging that we have not achieved the ideal of randomized controlled trials should not dissuade us from our commitment to adhere to well-grounded, best practices guidelines such as the Task Force Report on Children with Sexual Behaviour Problems (see references to access this report on line).

Safety and Supervision

Treatment universally begins with establishing safety and supervision. The expectation of sexualized behaviour treatment is that behavioural change is required to live safely. Until such changes can be made by the child the supervision levels need to be sufficient to ensure that the concerning sexualized behaviour has stopped or is successfully redirected in the moment, which often requires eyes-on monitoring, depending on the nature and intrusiveness of the concerning sexualized behaviour.

Based on Recommendations (from a sound assessment)

A comprehensive sexualized behaviour assessment is essential to understand the specific strengths and needs of a child to maximize the benefit of treatment interventions. Essential components of that assessment must include the following: family history (including placement history and current and historical involvement with treatment providers); developmental history of the child; academic functioning; social/recreational involvement; self perception; emotional functioning; trauma history; sexualized behaviour history and current concerns; adults perception of strengths; and a review of pertinent documention from collateral sources (e.g. plans of care, educational assessments; psychological/ psychiatric reports, etc.).

Strength Based

Being strength based in approach transcends all aspects of treatment in that it directs the individualization of the treatment plan. Whether the intervention is educational, new skill acquisition, substitution/modification of behaviour or relational in nature, treatment providers must incorporate the clients pre-existing strengths to maximize the positive outcomes of the intervention.

Belief in the Capacity for Change

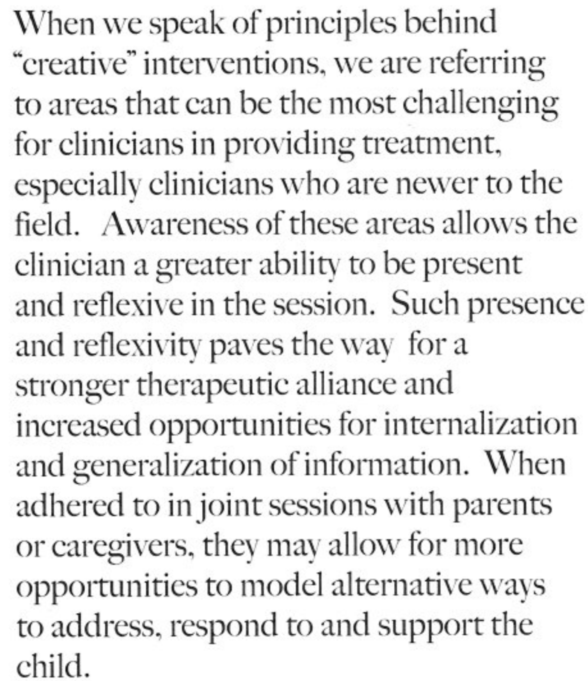
While all things are not possible for all people, goals that account for individuals' limits ensure that ones expectations of change are realistic. Having a balanced belief in change also ensures that, when necessary, the need for external supports is identified early and incorporated into goals and interventions.

Collaborative

Concerning sexualized behaviour can be an isolating phenomenon that divides and excludes. Collaboration ensures that the burden of change is shared and supported by a larger system maximizing the possibility for change and healthier relationships..

Treatment is Not Linear

The potential growth and change resulting from sexualized behaviour treatment can be limited by the confines of a linear approach to treatment (e.g. a leads to b leads to c). Children encapsulate the depth and breadth of all aspects of human development and can, depending on their experiences in and of their world, not progress fully or competently through various developmental stages. The complexity of sexualized behaviour in some cases necessitates interventions that can circle back to previous developmental stages to ensure that necessary foundational elements are present. Additonally, comprehensive sexualized behaviour treatment will touch on all aspects of the child including cognition, emotional functioning, behaviour and spiritual wellbeing. It would, therefore, not be unusual to introduce cognitive based interventions to address a certain treatment target, and then cover the same themes with emotionally based interventions while at the same time working with adults to support behavioural interventions.



When we speak of principles behind "creative" interventions, we are referring to areas that can be the most challenging for clinicians in providing treatment, especially clinicians who are newer to the field. Awareness of these areas allows the clinician a greater ability to be present and reflexive in the session. Such presence and reflexivity paves the way for a stronger therapeutic alliance and increased opportunities for internalization and generalization of information. When adhered to in joint sessions with parents or caregivers, they may allow for more opportunities to model alternative ways to address, respond to and support the child.

Developmentally Appropriate

It could be argued that no area of behaviour requires a more developmentally focused lens than concerning sexualized behaviours in children. The adolescent field has taken pain-staking efforts to differentiate themselves from the adult sexual offender population by recognizing the significance of the developing brain and the profound possibility for success in treatment as adolescents mature. For the pre-pubescent child, this is equally (if not more) true. The origins of children's behaviour must be understood and conceptualized up the progressive sequence of development and not have adult or adolescent meaning superimposed.

This can prove challenging as the child's actions may invite developmentally older interpretations of behaviour. For example young children have been described as "sexually provocative" in their presentation. A more accurate description would be that the child is acting, mimicking or playing in a sexualized manner. This places the emphasis on the acting and not on a sexual motivation. Further to this example would be the child who clearly uses this type of sexual presentation as a form of attention seeking or as an engagement strategy. Again the emphasis is on the function of the behaviour for the child, such as attention or engagement, and not sexual gratification.

Helping the child sort out developmentally appropriate behaviour with respect to sexuality requires the therapist to have a very solid understanding of the function the sexualized behaviour is serving in the child's life. Whether it is to reduce anxiety, engage with peers, decrease isolation or fulfill a craving for nurturance, the need will have to be met in a more developmentally appropriate manner before change is possible.

Creativity (YOURS or someone else's)

When we talk about creativity we are really calling on clinicians to be flexible in meeting the unique needs of the child

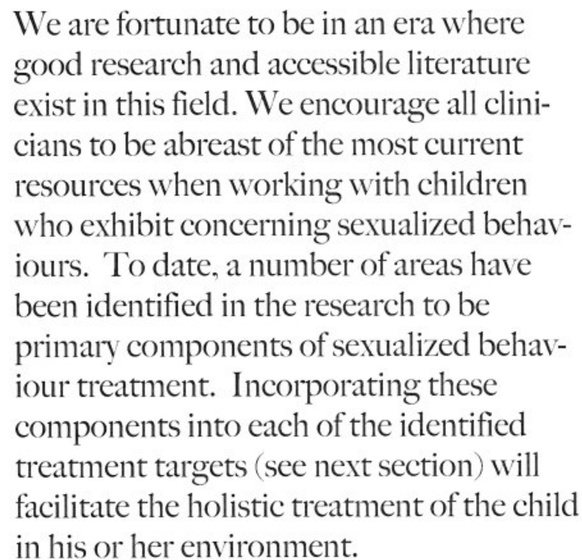
with which they are working. When using pre-existing treatment interventions, the clinician needs to understand the concept underlying the intervention as well as the target of the intervention. The intervention itself can then be modified to better fit the child's needs without loosing the integrity of the intervention, and still maintaining focus on the treatment target.

Once a clinician can view their role with their clients as an instrument of change they are better able to utilize interventions in a manner that frees up their own creativity. It is not about being artistic or having a great imagination. When the clinician is a) well grounded in the theory, components and targets of sexualized behaviour treatment, b) uses the guidance of a sound assessment and c) takes time to get to know the child, and can simultaneously hold onto these meta principles, the specific interventions will naturally evolve within the therapeutic relationship. Although the identified target goal remains the same (e.g., learning sexual behaviour rules) the creativity will be reflected in how the rules are learned (e.g., singing, rapping, skipping to or awarding prizes for correctly listing off the touching rules).

Thinking Outside of the Box

Structure and consistency are very important aspects of the therapeutic environment (and a child's environment in general). They create a sense of safety and predictability for the child and allow for learning to occur. However, children are also spontaneous, creative beings, reacting and responding to the here and now without much thought (or even ability to think) as to the how's and why's of behaviour. Our challenge, as adults and therapists, is not to box them in to OUR predetermined expectations as to how they should think, feel and behave. When we do this, we lose out on opportunities to really know the child, and support them in moving forward in a manner that is true and relevant to them and their experience in the world. Hence, our encouragement to explore interventions that build on or move beyond manualized treatment approaches. This is not to say that the manualized information available to clinicians is not worthwhile. It is, and it works well for many children. But not all children think/learn/develop in the same way and thereby require the clinician to tweak or create interventions to meet client needs. For instance, sometimes an intervention may need to be adjusted to reflect the child's learning style (more visual, auditory or kinesthetic) in order to allow for increased learning. Or, alternatively, it may need to be adjusted on the spot to reflect/respond to their emotional state (tone of voice, content of information being communicated, even where the therapist sits in the room) to allow for the child to experience adults being responsive to their needs.

SECTION 3: CREATING CHANGE—COMPONENTS OF SEXUALIZED BEHAVIOUR TREATMENT



We are fortunate to be in an era where good research and accessible literature exist in this field. We encourage all clinicians to be abreast of the most current resources when working with children who exhibit concerning sexualized behaviours. To date, a number of areas have been identified in the research to be primary components of sexualized behaviour treatment. Incorporating these components into each of the identified treatment targets (see next section) will facilitate the holistic treatment of the child in his or her environment.

Education: New Information, New Skills

Educating both the child and the adults in their world is a key component of sexualized behaviour treatment. Whether it is teaching sexual behaviour rules, age appropriate sexual health and development, emotional identification or alternative ways to regulate/manage these emotions, psychoeducation plays a key role. Younger children should be provided more concrete forms of education. Opportunities to interface with the information would likely include visual, auditory and kinesthetic elements (e.g. role playing). Children may benefit from explanations behind rules and opportunities to explore how the information translates into real world situations (a game you could call the "what if"... game). This would, of course, be dependent on their developmental level and learning preferences. When a child has the additional struggle of a diagnosed learning disability, it is the therapist's job to make the information accessible for that child. Having access to the child's educational assessment, and understanding the implications of their cognitive profile, can drastically alter how one engages the child in psychoeducational activities. Additionally, this knowledge would assist the therapist to help caregivers better understand the child's challenges and adapt their own interactions and expectations accordingly.

Adults who receive accurate information regarding normative and concerning sexual behaviour are better prepared to interrupt and redirect sexualized behaviour. They are also more equipped to both praise a child for appropriate behaviour and manage their own emotional responses to the sexualized behaviour, with the additional benefit of modeling emotional regulation for the child. Finally, having a child teach a caregiver what they have learned in session reinforces learning of the concept, and creates an opportunity for the parent to provide positive feedback to the child, as well as to develop a practice plan (see below in the Practice section).

Self Awareness: Them in their World

We know that all children react to their worlds in complex ways and often as a result of what is happening (or not happening) in their environments. Depending on their age, developmental stage, temperament, past victimizations and the degree of stability in their world, to name but a few, children will respond/react differently. Their responses, however, are not often linked with cognitions in a manner that is accessible to them (i.e., insight). Such reflection usually comes with later developmental stages and/or with the assistance of therapy. On a normative developmental trajectory, children gradually learn and integrate the concepts of empathy, self care, boundaries, privacy and what to do when, how, where and with whom. They make mistakes, self correct or get corrected and move forward towards greater awareness of self and other.

When a child is exhibiting concerning sexualized behaviours and has not been able to respond to the limits others place on them, chances are the behaviour is linked to the child's past and/or present environment. Understanding the behaviour in that context is paramount to developing an intervention that addresses the current function of the behaviour for that child. Take for example, a child who is being referred for excessive masturbation and who has been raised in a family where a parent struggles with mental health issues. The child may be HIGHLY sensitive and responsive to the needs of others, to the detriment of meeting their own needs (or having their own needs met by others, as would be more developmentally appropriate). Excessive self stimulation may be one of only a few self soothing behaviours the child has. This is not a cognitive construct for the child, but a behavioural response to a situation that has developed over time. Knowing this information changes the lens on the behaviour and shifts the therapeutic response to not one but three target areas: a) decreasing the child's parentified role in the family, b) increasing the ability for others to care for and respond to the child's needs and c) assisting the child in discovering (and being empowered to use) other self care strategies. As these treatment targets are addressed alongside psychoeducation pertaining to what, when, where and in who's company the child can engage in self stimulating behaviours, the child's self awareness will naturally evolve, resulting in a behavioural change, even if the underlying reason for the change is not accessible to them on a cognitive level. In contrast to this, if the focus was solely placed on the cessation of the concerning sexualized behaviour without addressing the underlying concerns, we would in essence be instructing the child to not take care of themselves, and thereby inadvertently reinforcing the messaging in the family.

Increase Circle of Support (other awareness): Increased Connections, Improved Relationships

As indicated in the above example, we often need to cast a wider net then just working with a child on his/her concerning sexualized behaviour. In assisting others to respond to the child in a positive, prosocial and developmentally appropriate manner, and correcting for disruptions that may put the child at ongoing risk to engage in concerning sexualized behaviours, we are communicating to the child that they are supported in a variety of contexts (home, school, daycare). Educating others who will be supports for the child is a key component, as adult responses need to be based on accurate information rather than being reactive and shaming in nature. Increasing support for the child can lead to an improvement in relationships and assist the child in developing a greater understanding and appreciation both for the interconnectedness of relationships as well as the opportunities for correction and change that they allow.

Practice: Out with the Old, In with the New

Whatever is "learned" in therapy needs to find a way to be enacted in real life in a manner that is meaningful to the child. This often happens as a result of the child and his/her caregiver agreeing on a plan to manage the behaviours. Such a plan would not only address what the child "should not do" but also what the child "should/could do instead" and how the parent/caregiver can best support him/her in doing this. Caregiver interventions such as charts, stickers, daily positive reminders and debriefs can all be tools to assist a child in moving away from a behaviour. Celebration of successes, even small ones, is encouraged. Such interactions can also foster emotional connection if done correctly.

Situations where a child who is able to recite back sexual behaviour rules, but continues to break them on a daily basis beyond what would be considered an appropriate length of time, suggest that for some reason they are not able to integrate, utilize or generalize the rules in their every day existence. If the child "knows" the rules, and behavioural experiments are indicating ongoing concerns in spite of the adults being educated and responding appropriately, one must look more closely at what is maintaining the behaviour and address those elements of the child's existence. We will speak more to this in the section dedicated to consultation.

To date, the literature identifies a number of areas that are often considered primary treatment targets for concerning sexualized behaviour. However, the "one size fits all" rule, again, does not apply. In addition to following general best practice guidelines, therapists must refer to the assessment, as it can provide guidance as to whether particular treatment targets should be included in a treatment plan.

Emotional Regulation

Numerous evidenced based programs have been developed and are used widely across North America to target emotional regulation. Depending on age and developmental stage, in addition to other factors, children with concerning sexualized behaviour may not be "fluent" in the expression of feelings and may have a very limited knowledge and facility with emotional identification and expression. Given this fact, we often start with ensuring the child has a clear understanding of emotions in general (e.g., happy, mad, sad). We might start a session with, "Today we're going to talk about feelings. Let's make a list (draw pictures/cut out pictures) of all the feelings you know about." We might then move onto, "When might a person feel this way?" in order to gain an understanding of the scope of their knowledge connected with a specific emotion. Once this is done, we would then connect that to expression: "How might they act when they feel this way? How might you act when you feel this way?" Again, the therapist and the child can act these out, draw these out, play 'guess my feeling' using the therapist's own face, make lists, create a matching game or make a collage, to help internalize the learning. When appropriate, and if the child does not identify the concerning sexualized behaviour him/herself as related to feelings, the therapist can ask, "Help me understand how the (touching problem) fits in here?" Depending on how the child does with this exercise, the therapist could also elicit responses to questions such as, "How would you like ______ to treat you if s/he is (mad/sad/excited)?" to inspire alternate, hopefully more prosocial responses. Once the therapist feels they have a clear understanding of the child's baseline knowledge and expression, it is possible then to work with the child and his/her caregivers to expand that knowledge as well as their behavioural responses to emotionally charged situations. Together you could develop a game, create a play, write a song or a children's story demonstrating the naming of feelings and ways to manage/react to each. There are also a number of children's stories available that address feelings that caregivers and children can read together. When addressing the concerning sexualized behaviour, it is critical to assist the child in matching his or her emotional response to the situation that elicits the behaviour. This work is not limited to pairing a small/medium/large emotional response to the situation but also requires addressing the sexualization of emotional responses.

As a child becomes more "fluent" in the language of feelings, and is provided consistent, alternative behavioural responses to their expression of them, the child can develop new patterns of emotional responses that no longer include sexualization.

Experiencing adults in their life who are able to provide the attentive, empathic responses they seek will also serve as a strong model for their own capacity for empathy and ability to be attentive to others.

Impulse Control

As above, there are also many evidenced based programs targeting impulse control. These interventions can be used and adapted to meet the needs of particular children and their families. Additionally, it is important to be cognizant of other factors that impact on impulse control such as family history, attachment styles, ADHD, past traumas and hypervigilance. A thorough assessment should be able to identify any of these outstanding issues and whether they require further assessment or need to be addressed in therapy. Impulse control techniques are only successful if they are generalized. A child who struggles with impulse control can often engage with the concepts being worked on in the therapy room and appear to be clear on the steps to take to reduce impulsive responses (such as reducing/eliminating sexualized language in the school yard, grabbing others genitals, etc.). However outside of the therapy room, the interventions (e.g., the STOP and THINK technique) do not "stick" in some situations. Generalization is possible only when the therapist has a clear understanding of the role that emotion regulation plays in managing (or inhibiting) one's impulsive behaviours. This is an example of the non-linear nature of sexualized behaviour treatment, as it overlaps and intersects with affect management interventions. Finding out what is maintaining the behaviour by being curious, "Wow, I wonder why our plan didn't work?" may be the first step to understanding. Using therapeutic interventions like role playing, making a movie, developing a mantra or enlisting the help of adults may also assist the child in experiencing more success at controlling their behaviour. And then, of course, it is important to celebrate every success!

Trauma Symptom Related

There are a number of pathways that connect past trauma with sexual behaviour problems. A history of sexual abuse can result in confusion regarding rules and boundaries related to touching. Physical responsiveness during a sexual abuse experience can increase the confusion leading to replication of the behaviour. Exposure to pornography can also lead to a replication of what is seen. Neglect and chaotic abusive home environments, including witnessing intimate partner violence, can result in self stimulation as an anxiety reducing behaviour.

Viewing the behaviour in relation to early experience, when applicable, is essential in considering an intervention. This concrete

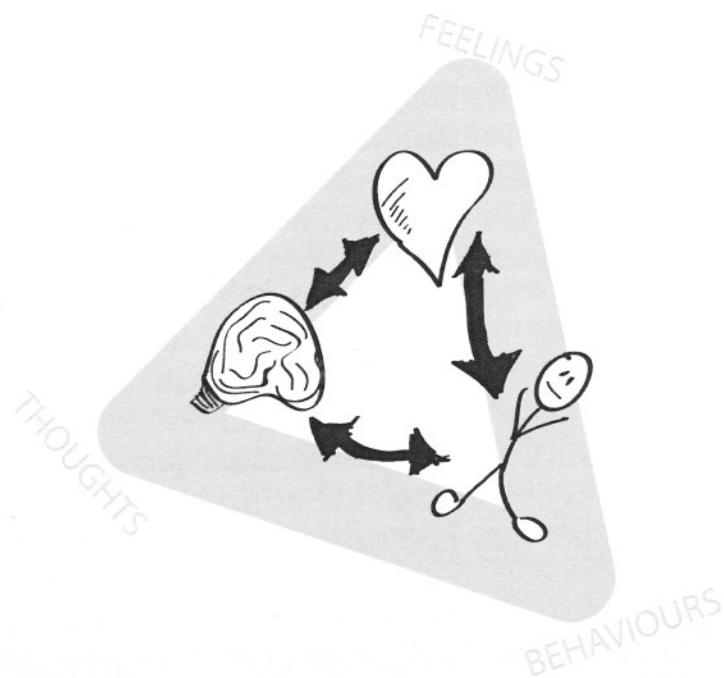
connection may be important to include as part of the work in order to help the intervention "stick." The differences between interventions that create such linkages and those that do not are fairly straightforward. For example, when addressing self stimulation, one can simply focus on education, using rule based interventions if this is what is clinically appropriate. However, if the behaviour grew out of a more complicated history (e.g. stimulation was a means to self soothe in a home where domestic violence occurred), then combining rule based interventions with a narrative story of alternative ways of calming yourself down would provide a deeper connection to the solutions being generated, as well as to the rules.

Education—Child

Education is both a component and a target of treatment. Children with concerning sexualized behaviours benefit from information pertaining to healthy touch and sexual behaviour rules, age appropriate sexual health education, identification and expression of emotion, secrets, coping strategies and, depending on the age of the child, what the law says about sexual behaviour and consent. As children learn about these topics, they can also teach the adults in their lives during joint session time.

Education—Adult(s)

Adults require education as well, and often in the case of concerning sexualized behaviour, information specific to what is normal and what is concerning can be very helpful. Unfortunately, adults can often overreact to normative behaviour, sending confusing messages to children in regards to sexuality as a whole. Adults can also benefit from education on the difference between what prompted the development of sexualized behaviour and what maintains it. Such a focus on maintenance can lead to an exploration of how they can change/address their home/school/daycare environments to reduce opportunities for and enhance responses to sexualized behaviour. Although children can be good teachers for the adults in their environments, often the adults benefit from formal education as to how to respond to the child's efforts in a manner that will foster on going communication and reciprocal learning opportunities.



SECTION 5: CREATIVELY INTERVENING—EXAMPLES FROM CLINICAL PRACTICE

This next section will take the reader through a number of creative approaches to various interventions. Our intent is to assist the clinician in creating and customizing interventions with their clients in a manner that will meet the client's unique needs.

Examples Concerning Rule Setting

When we think of socialization of the preschool and latency age child, rule setting is paramount in teaching appropriate behaviour. Barbra Bonner and her colleagues (see references) documented the essential aspect of rule setting in the area of sexualized behaviour treatment. This section of interventions begins with the generation of the list of rules and demonstrates various ways of incorporating specific locations or customized sets of rules. Consider customizing your list of rules to the child when a general list is not successful, the child is very young and/or the child is very concrete and struggles with generalizing principles to novel environments or situations.

General

- No touching private parts.
- No pulling down pants.
- No showing privates parts to others.
- No looking at other peoples private parts.

Rule setting customized to situations or locations

- No pulling down pants even if every one laughs.
- No pulling down pants because some one asks you to.
- No pulling down pants in the class room, hall or outside at school.

Bathroom Rules

- Only one person in the stall at a time.
- No peaking over or under the stalls.
- No playing in the bathroom.
- Wash hands but no playing in the water or splashing.

Touching Rules

- No kissing, sucking or licking private parts.
- No putting fingers, toys or stuff in bums.

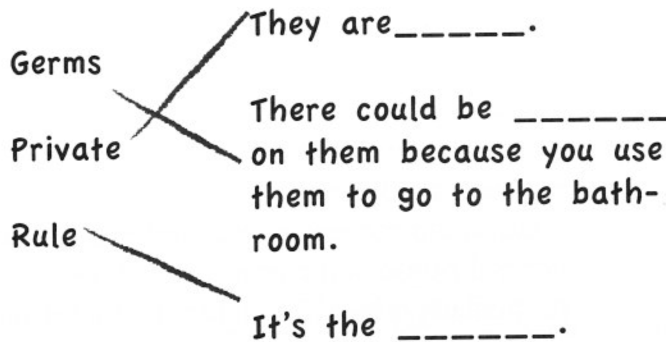
The presentation and review of these rules is open to as much creativity as needed to ensure that the child's learning is maximized. Repetition and Review are critical teaching strategies used with young children. Building on other lists of rules that are already known and used by the child can access cognitive constructs that increases the likelihood of retention. Sufficient supervision to ensure that compliance with the rules is met with immediate correction and consequence is also important for incorporation of rules into routine. Teaching the rules to others is not only a confidence builder, but also allows a natural observation of the child's comprehension and generalization of the principles. This is particularly critical for children with learning challenges that are masked by strong verbal skills.

Examples Concerning "The Whys" (to support Second Order Changes)

Therapists need to provide contextual information to assist the child in making sense of the reasons behind a rule. Young children retain and follow rules when they make sense and have a logical explanation. For example, the rule, "Look both ways before you cross the street. This makes sense because if you don't you will be hit by a car and be hurt very badly." Stories and games provide a developmentally normative vehicle for the information to be shared. This is particularly relevant in the case of trickier questions.

Using Games:
Turning the generation of reasons behind rules into a game may provide more active engagement for a more active learner. An example may be a game designed to fill in the blanks or create matches with pre-made lists of responses.

No touching private parts because...



Using Stories:
We don't put things up our bums because...?

"Bums are a special tube that lets the left over food we don't need come out of our bodies and into the toilet after our bodies get all the vitamins that help us grow out of our food. The tube is one way only so things don't go in our bums. If one day we forgot that rule and put something in our bum—oops!—it could get stuck. Then we would have to stop playing and get the doctor to get it out. The doctor would scratch her head and say oops, things don't go in our bums because they get stuck and can make you sick."

We don't touch dog's private parts because...?

"Dogs are animals they are not people. Dogs speak in dog language and people speak in people language and when you speak different languages it's very hard to understand what is being said. Private parts are private and you have to ask to touch them. You can't ask a dog because the dog doesn't speak people talk and the dogs ears wouldn't know what you were saying. If the dog talked in dog talk your ears wouldn't understand the dog's words either. Plus private parts are for going to the bathroom. Private parts can have germs and if a dog gets people germs it can make them sick or if people get dog germs it can make people sick too."

Examples for Developmentally Appropriate Sexual Health Education

Parents and clinicians alike struggle with putting into words (in a developmentally appropriate manner) the pleasure and positive aspects of sexual behaviour. This is particularly true when we begin to address concerning sexual behavior, as messages about the pleasure inherent in the behaviour seem counter-intuitive. However, to ignore the positive messages their bodies are sending their brains is not helping them navigate their real world experience, particularly since our Western culture places such an emphasis on sex. By using a narrative therapeutic story approach, sex-positive information can be delivered in a format that is both child and adult friendly. Here are some examples of how you may want to approach a topic such as "sexual touching feels good", ensuring that corrective rules are being promoted, while acknowledging and normalizing that touching private parts feels good.

Private Parts Feel Good Story

Private parts feel good for a very good reason. It's a science reason. It's for reproduction, which is the science word for "make a baby." Cats have kittens and dogs have puppies and humans have babies. To make a baby, a grown up boy and a grown up girl have to rub their private parts together. To know what parts go together, they put extra nerve endings in those parts. Nerve ending are the thing that gives us feeling. There are more nerve endings in your finger than there are in your elbow. There are the most nerve endings in your private parts so that grown ups know to rub them together. If grown ups didn't do that then we would not have babies and become extinct like the dinosaurs.

Touching Self Story

It's okay to touch your own private parts because they are yours. You have to touch them in the bathtub to wash them or they get stinky like old socks. You can touch them by yourself if you want but not in front of other people. That is rude because they are private.

Touching Self Feels Nice and Makes You Happy Story

It's okay to touch your own private parts because they are yours. They can feel warm and very nice to touch, and make you feel calm and happy. Touching yourself can cheer you up and be relaxing to fall asleep. But we are people and people need lots of ways to feel safe, warm, calm and happy. Life can have bad days and we need to have lots of ways to cheer us up and relax to fall asleep and have a better day tomorrow. What are other things that help you on a bad day? Make a list with pictures.

Masturbation Story

When your body starts to grow it's called puberty. Your private parts grow too and get to be a grown up size. They start to work like grown up parts exactly when they are supposed to for you. Every one is a bit different when their bodies start to grow. Once you have grown up sized body parts, when you touch yourself that is called masturbation. It is still okay to touch your private parts but remember its private and you only do it when you are by yourself. Adult private parts like being touched very much because of science, reproduction and survival of the species. Masturbation is part of making sure your body parts work long before you are old enough to make a baby. The decision to have a baby is very complicated because you have to be able to take care of another human being, which is a very difficult job. Even once you know that your body works, it is okay to continue to masturbate in private so that you can learn about your body and what your body likes. Sexual relations is sharing between two people and it is easier to share your body with someone else when you know about it yourself. Masturbation is also very helpful in knowing what turns you on. What you think about when you masturbate is very personal and unique to each person. Everyone has a list of things that turn them on. The more you masturbate to an idea, the bigger the space it will take up on your list. So you have to make sure your thinking part of your brain has gone over your list to make sure you agree with all of the sex ideas on it.

What is very interesting is that this list is there when we are born and sits in our brain even before our sexual body parts start to work. Some things can get added to the list that do not belong there. So when you first start to masturbate and think about things that turn you on it is very important to ask yourself "how did that get on my list...do I want that on my list...is this legal to have on my list?" You want to ask yourself is it healthy and okay for me to keep thinking about this while masturbating because masturbating to an idea makes that idea stick stronger to your list. Thinking of young children when you masturbate is illegal and will lead to problems in your life. Children before puberty are not sexual and do not want to do sexual touching like teenagers or adults. There are lots of things that can get on your list that once you think about it you decide to take off your list. One question that can help you decide if you want to keep it on your list is whether you think it's weird or maybe you guess a partner would think it's weird. Be very careful with sex ideas that you get from pornography. Even though it is not a cartoon the pictures and movies you have seen are mostly made up and not real. Another good question is to ask yourself is if your sex idea is against the law. The laws in Canada/USA/Australia are: ...

Examples to Deal with Confusion: Lots of things can get MIXED UP

Activities in this area are not intended to create causal links between past experiences, particularly victimization experiences, and current sexualized behaviour. They are intended to help the child make sense of their current behaviour and how they might have gotten mixed up. While, in a number of cases, connections to past sexual victimization may appear very compelling, there are equally as many victims of abuse who do not engage in sexualized behaviour. However, on an individual basis it is important to acknowledge and work with a child's response to, "Where did you get the idea about the touching?" The purpose of using a narrative story is that it sets the stage for the original "mix up" situation. The story should be written with an ending that clearly outlines the moment in which child realized they were mixed up and what they did from that point forward.

With older children you might generate a chart type list to help separate and differentiate "sexual touching ideas" from "playing ideas" or from "being friend ideas." This activity can be expanded upon through connecting behaviours to categories or in a memory-type matching game.

For many children, common areas that can get mixed up with touching are as follows:

- Sexualized touching mixed up with regular playing.
- Friendly touching with friends (arms linked, hugs, wrestling) mixed up with sexualized touching.
- Appropriate touching rules mixed up with sexual touching rules learned by others.

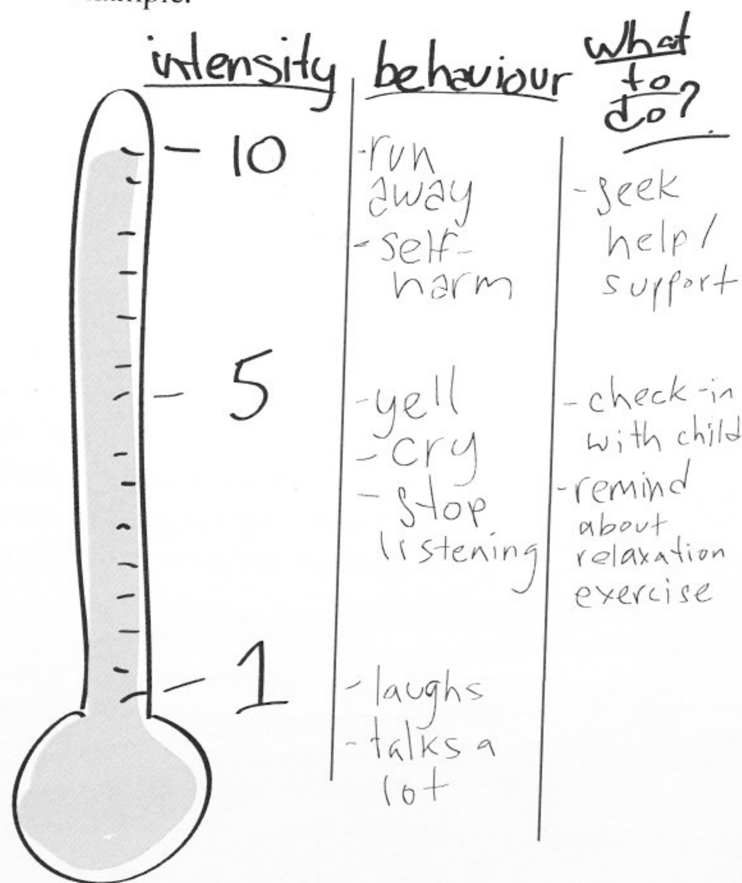
Choosing to frame sexual behavioural errors in terms of being "mixed-up" is most appropriate for pre-school and early latency aged children. This allows a preservation of their positive self image while also capitalizing on their developmental desire to be rule followers. Seeking out positive adult attention and recognition is a strong motivator that parents and teachers can capitalize on. Wanting to please adults sustains the positive connection while reinforcing positive behaviour, a cornerstone of socialization. Success should be counted and positively weighted. This, when combined with a swift, clear, age appropriate consequence for rule breaking is capitalizing on the best Behavioural Theory has to offer.

Examples to address Emotional Regulation

There are many tools one can use to assist children and their parents in monitoring and managing emotional responses. Many

of these tools are used in conjunction with the development of coping strategies (see below). This is one of the target areas where CBT (Cognitive Behavioural Therapy) is highly effective, but adaptations may need to occur to allow the child to understand and integrate the information. Using the cognitive triangle (thoughts, feelings and behaviours) in a game like manner (e.g., masking tape on the floor in the shape of a triangle) can provide a kinesthetic experience of connecting behaviours to feelings and thoughts to situations. Walking (hopping, jumping) through the triangle and mapping out connections to everyday events (e.g., feel hungry, think about a cookie, get a cookie—then looking at alternative behaviours—get a banana, get a glass of milk) is a way to make the concept fun and understandable. Eventually connecting feelings and thoughts to past sexualized behaviour (if they are able to do this) or to alternative behaviours is a way to bring about insight and planning for future, healthier responses. For older children, chalk boards and white boards are also useful as they allow for bigger drawings and for the child to be more easily engaged if they are doing some/all of the drawing and writing. Children can also draw, cut out of magazines, and use stickers to represent thoughts/feelings and behaviours connected to the various situations the child presents. Often times, however, the cognitive triangle is too complex for younger children or children who learn differently. In response to this, we can use a heart to depict feelings, a brain to depict thoughts and a stick body to depict behaviour. The child can still be walked through the connections, and then look for "escape routes" or alternative behaviours. Of course, eliciting the support of others in their lives is very important when trying to change behaviour. Having the child reflect on their heart/brain/body pictures with supportive adults is one way to elicit such support.

Another tool that is used to help children and their caregivers identify the nature and intensity of emotions are feeling thermometers. There are many templates available online, but they are also easy to draw. Not only are they good for feeling identification, but they help both children and caregivers identify together the behavioural indicators of emotional intensity and how both are to respond at each level of intensity. When completed together, the therapist can draw from narrative approaches to emphasize the teaming up of caregiver/child against behaviour. For example:



Another tool that can be beneficial in helping a child define how "intense" their emotion/ feelings are is an image of something that can get filled up, like a glass, a bucket or an object that is meaningful from the child's life. We have used the image of a drinking glass (but you can also use the real thing) very successfully to measure how big a feeling is, allowing it to "overflow" if that is the child's experience of the intensity of a feeling.

Examples to Address Coping Strategies

Coping strategies are fun and relatively easy to teach, especially when they are linked to practice activities. Basic coping strategies are often mindfulness based and can be reinforced by encouraging caregivers to enroll the child in yoga or other classes that allow the child to become more mindful of their body. Belly or balloon breathing are often taught to children using a balloon and/or a straw. The balloon helps the child visualize the expansion of the belly when breathing in, as well as its "deflation" when breathing out. The straw helps the child understand how to breathe slowly and modulate their breathing. In terms of "the why's" behind breathing, younger children can understand it as a simple, "It gives you time to stop and think of another way to act" or, "It helps you relax and when you relax you are able to make a decision that does not break a rule." Older children can understand some of the science behind it, "When you breath in deeply there is more oxygen that goes into you. The blood takes the oxygen through your body and to your brain. Brains need oxygen to think clearly so breathing deeply helps you to think more clearly and and make better decisions."

Children love to teach this tool to their caregivers and both are encouraged to practice together at bedtime as belly breathing can also promote relaxation that can aid sleep. Charts can be made as reminders to practice and extra stars can be given when a child reports back that they used belly breathing to help them manage their feelings or think differently about how to behave. Another coping strategy that children (and caregivers) can utilize is PMR (progressive muscle relaxation). Barbara Bonner has a great pictorial worksheet to use with children. Children may have their own thoughts about images that might help them use PMR. Making their own chart, or coming up with their own images can make it more relevant, and then doing the exercises together helps to reinforce the concept. Therapist and child can take turns beginning or ending the session with PMR. Putting the child in the teaching role with the therapist empowers them and assists in developing feelings of competency in alternative ways of coping with emotions.

Assertiveness training is another element that is often taught in connection with coping strategies. Many times, children lack the verbal skills or knowledge to respond to a situation in a more socially appropriate manner. Role playing how to make a friend, how to say no to a friend, recognizing personal space and boundaries and even how to ask for something from someone provide children with alternate behaviours and skills that may aid in the interruption concerning behaviours. Role plays can be done between the clinician and the child, but can also be done with dolls, puppets, toy animals and even home made paper dolls.

Examples to Address Second Order Change

As with most things complex, when the elements are laid out concretely, children have the amazing ability to synthesize information into a meaningful gestalt. Once understood they are then able to move forward—problem solved. This reflects the progression from first to second order change. First order behavioural change is achieved through compliance with rule setting. To sustain this, however, second order change is required which addresses the meaning and function of the behaviour for that specific child.

We often associate the need for greater insight as a component of adult therapy. But never underestimate a child's need to make sense and meaning of their lived experience. Consider a narrative that was created by a nine year old making sense of her sexual behaviour with her sister. While insight does not necessarily lead to change it certainly was essential to sustaining this child's decision to be a rule follower. Note how trauma history, exposure to pornography, physical responsiveness, neglect and deprivation of nurturance needs all played a role in the sexual behaviour. While learning and enforcement of the rules was responsible for the 'first order' behavioural change of the sexualized behaviour, it was interventions that addressed the underlining issues that are responsible for the 'second order' or sustaining change. This story was written with the client in session as a narrative response to a 3D craft/science project she had made. The co-writing process was done by the therapist setting up the first part of the sentence and then pausing, allowing the child to fill in the pause. Sometimes a direct question is necessary to prompt the child's response (e.g. What are the names of the girls private parts? Why do breasts like to be touched?). In co-writing a story there may be opportunities to interject some psychoeducational material that may be a review or new information. Always take the opportunity to provide accurate information even when the story leads in a direction you did not expect.

How come Private Part Touching is So Complicated?

Private part touching is complicated because it is hard, confusing and difficult to figure out. The hard part is the science of the body. Private parts on a girl are for peeing and having sexual relations. Having sexual relations is part of life and reproduction (making a baby). So a body is made so private parts like being touched. Breasts like being touched so a mom knows to use them to feed her baby milk so the baby does not die. Remember baby bottles as we know them are only 100 years old. Pioneers didn't have them. The vagina likes being touched because that is the part that rubs against a boy to make a baby. That is the science part.

The confusing part is the porno's. They showed a man and a woman having sexual relations but no mention of a baby. Then there were two girls touching private parts and two women can't make a baby. So they must be lesbians which is the girl version of being gay which I heard about last night because it's gay pride week. When you are a teenager you are more ready to decide if you like boys or girls. It's confusing to figure that out before

you are a teenager because you don't have enough information.

When you are in grade 4, 5 and 6 you can like a boy and call them your boy-friend or say that you're dating but it's not the same as teenager dating. Liking a boy means you like them and don't know what they think and are too shy to find out. Having a boyfriend means that you like them and they like you back. Dating in grade 4, 5 and 6 means that you might walk and talk together around the school yard or the boy might walk you home if you don't take the bus. When you are in grade 4, 5 or 6 and dating you don't really hug or kiss because that's still gross and you usually have to wait till you dance with a boy at maybe the grade 6 dance or wait if you are shy till grade 8—no rush.

Then there is the "difficult to figure out part" which is the rules. No touching private parts when you are a kid; No touching private parts if they are in your family; you have to ask first; and you have to be old. Because there is a lot of wrong information out there you really need to check it out. There is a boy named John at school that said kissing was sex but that's not right.

So...
Hard Science + confusing sex things + difficult to figure out rules = Complicated private part touching

No wonder kids can get mixed up.

The End.

Often times the realities of our clients lives leaves them with very difficult pieces of adult sexuality to put together. The following example is a little story that captured two complicated pieces of confusing information for this same client. There is no further explanation needed. It is simply noted as confusing and for this developmental stage, that was all that was necessary for this child to move forward. It was processed and labeled as confusing.

And so the story continues:

Another more confusing part of the porno's was the penis thing one of the girls had. Mom had a penis thing. It was very confusing and when we would go into her room she would try to hide it so we didn't see. Dad had porno's and mom had a penis thing. Very confusing.

SECTION 6: Creating an Intervention Using the Worksheet

It can be a very difficult process for newer clinicians to determine what areas to focus on and how best to approach each area when working with children exhibiting concerning sexualized behaviours. Working from a sound assessment and having good clinical supervision are keys to starting off on the right foot. But customizing interventions to suit a child's unique profile can be a daunting task. In an attempt to provide a sound basis for decision making in this regard, we have developed a worksheet that can be used to synthesize information that would be helpful for clinicians to be mindful of when choosing and tailoring interventions. The intent is to help the clinician expand their knowledge of the child, focus on the child's strengths and uniqueness and ensure their approaches are grounded in the research. The worksheet, as a whole, challenges the clinician to do the following:

Consider...

...the meaning and function of that behaviour for that particular child--when it began and currently. Answers will come from the assessment, which should have captured the view of the child, parents and caregivers.

Check...

...with the guidelines. What are the recommended principles that should be included in the intervention?

Awareness ...

...of the age and stage of child. What do you know about developmental theory as it applies to this particular child?

Think about...

...the child's learning needs, style, differences.

Once the worksheet is completed, the clinician is reminded of the clinical conceptualization of the child and the larger intent of the intervention. This then leaves them free to be present with what the child brings to the session and use it in a meaningful way. Please refer to a completed case example to expand on the concept.

CASE EXAMPLE

Client is 5 year old Kyle. His mother is a single parent experiencing mild depression after recently leaving violent relationship with Kyle's father. His mother reported that Kyle would often wake in the morning and his father's pornographic movies would still be in the DVD player. The family is isolated with extended family 250km away. Kyle has had some difficulty with friends in his class, as he can be bossy and demanding. He does maintain friendships, however, because of his athletic ability, humor and sense of adventure. The teacher is somewhat worried that he will struggle next year with the routine and structure of grade 1, as Kyle loves to share his stories and entertain the class. She has some concerns regarding his reading readiness, but his creativity with the Science and Number Centre mitigates her academic concerns at this time.

Concerning Sexual Behaviour:

- Derogatory sexual language particularly towards girls in his class and female teachers.
- While wrestling with boys from his class at recess the other boys complain to the teacher that Kyle is grabbling their penises, which he calls his death grip move.
- Told his female grade 6 reading buddy to "show me your boobs."
- Was caught looking under the stalls in the bathroom.
- Draws breasts and penises on stick figures in provocative sexual positions.
- Will often turn play at the classes house center into "the kissing game" or "being married game."

Please see the following page for an example of a completed Sexualized Behaviour Treatment Worksheet for the above case example.

Sexualized Behaviour Treatment Worksheet

Targeted Behaviour:	SEXUALIZING PEER RELATIONSHIPS
Current Meaning and Function of Behaviour:	CONNECT TO PEERS, FIT IN, GET ATTENTION FOR BEHAV. (POSITIVE & NEGATIVE)
Research Directives:	CBT WITH CHILD & PARENT, TEACH SB RULES, COLLABORATE WITH SCHOOL FOR A UNIFIED APPROACH

Developmental Factors

Cognitive: 5 YEAR OLD. FUNCTIONS AT GRADE-APPROPRIATE LEVEL
Emotional: ISOLATED, WITNESS DOMESTIC VIOLENCE, POOR PARENT-CHILD RELATIONSHIPS, EARLY PORN ACCESS
Behavioural: BOUNDARY VIOLATIONS, DIFFICULTY RESPONDING TO REDIRECTION
Physiological: ?

Learning Profile (to match intervention to strengths)

Auditory 1-------------------5-------------------10 ?
Visual 1-------------------5-------------------10 ?
Kinesthetic 1-------------------5-----------X---10

Identified Challenges: MOM DEPRESSION, ISOLATION, TRANSITION TO GRADE 1, NO MALE ROLE MODEL
Identified Strengths: HUMOUR, FUN LOVING, HAS FRIENDS, ACADEMIC STRENGTH, YOUNG AGE (LOTS OF TIME TO REPAIR BEHAVIOUR)

Target Audience

✓ Individual ✓ Caregiver(s) ✓ Community

Treatment Interventions:

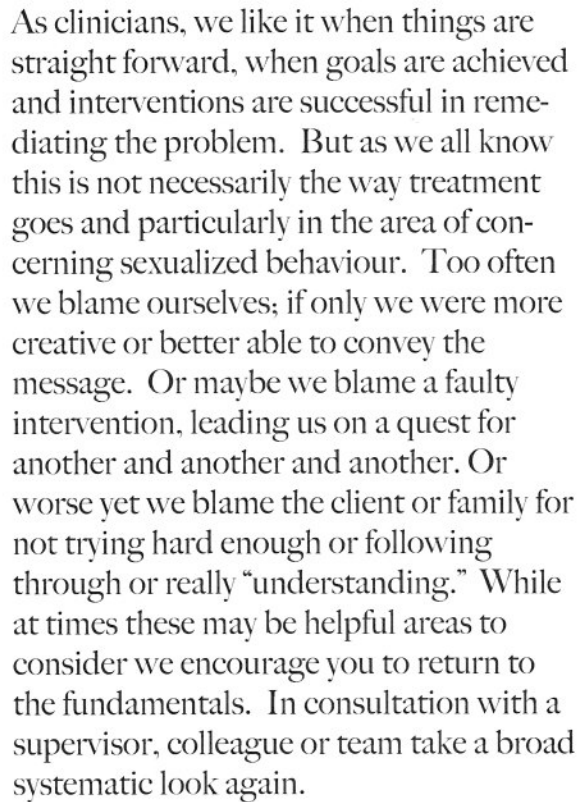
Psychoeducation: CHILD: REVIEW PLAYING RULES, FRIENDSHIP RULES, SB RULES SCHOOL: EDUCATION RE: SUPERVISION, CLEAR CONSEQUENCES, REDUCE STAFF ANXIETY RE: BEHAVIOUR
Interventions with Child: IDENTIFY & ADDRESS WHAT'S "MIXED UP" USING PICTURE LIST, ACE OF FEELINGS KINESTHETIC GAME TO TEACH SB RULES
Interventions with Others: HIGHLIGHT IMPORTANCE OF MOM'S EMOTIONAL CONNECTION WITH CHILD, GET MOM TX FOR DEPRESSION, COME UP WITH SUPERVISION PLAN AT HOME
Practice Recommendations: • TEACHER TO PROVIDE WEEKLY FEEDBACK, CHILD BRINGS TO SESSIONS • REINFORCE POSITIVE INTERACTIONS & APPROPRIATE BEHAVIOUR

Required Supplies:

1. PAPER
2. PICTURES
3.
4.

Heather Barbour/Karen Holladay, 2011

SECTION 7: BACK TO THE DRAWING BOARD— THE IMPORTANCE OF CONSULTATION



As clinicians, we like it when things are straight forward, when goals are achieved and interventions are successful in remediating the problem. But as we all know this is not necessarily the way treatment goes and particularly in the area of concerning sexualized behaviour. Too often we blame ourselves; if only we were more creative or better able to convey the message. Or maybe we blame a faulty intervention, leading us on a quest for another and another and another. Or worse yet we blame the client or family for not trying hard enough or following through or really "understanding." While at times these may be helpful areas to consider we encourage you to return to the fundamentals. In consultation with a supervisor, colleague or team take a broad systematic look again.

Return to the assessment. Typically the first recommendation talks about the necessary foundation that is needed for treatment to begin. The most common initial recommendation is "living in a safe, stable nurturing environment with adults who are supportive of treatment." Does this area need to be re-explored to ensure there is the safety and stability necessary to allow for change? Were there other placement recommendations or access recommendations that have not been implemented? Are there other areas of the child's life: school, caregiver issues, housing, basic needs, that are getting in the way of stability in the broadest sense of the word? Is the child safe, and equally important, are others safe with the child? Is there indeed "enough" supervision that the sexualized behaviour has stopped or is minimally addressed with consistent redirection/consequence?

As the treatment provider, you now have experience working with the child and are able to return to "assessment type" considerations regarding the child's learning abilities or other obstacles that interfere with behavioural change. For instance, are you now in a position to rethink the function of the concerning sexualized behaviour or develop a new hypothesis regarding its etiology? Have you been able to build appropriate behavioural replacements for the function the concerning sexualized behaviour played in the child's life? If the concerning sexualized behaviour was used as an engagement strategy, social isolation is an unpleasant alternative. How much practice does the child need to be able to be successful in their new replacement skill in order to successfully navigate social relationships? Have you mistakenly assumed that because you taught, for example, two new social skills for peer engagement, that they are working on the play ground? Have you checked in with the child's circle of support, teacher, educational assistant, daycare teacher to confirm progress or is there evidence that the child is being left out and excluded? Might this dilemma be addressed by some encouragement before

break time or some side line coaching from the educational assistant?

Typically when you begin interventions you stick to simple interventions that target one area that is directly related to stopping the concerning sexualized behaviour. In the majority of situations, emphasis on the rules, parental supervision and interventions that support change are very effective. However, when these interventions are not effective this type of systematic review can identify the unique dynamics that may be at play. It is these cases in which you often see the need for building and layering of interventions that will cumulatively address the treatment targets. An excellent example is a case where the sexualized behaviour serves as the primary self soothing function in the child's life. Increasing a child's emotional coping strategies requires a layered approach to feeling identification, appropriate labeling, identification of supports, and finally developing multiple coping strategies for distressing emotions. With each intervention it is essential to evaluate the child's developmental foundational blocks. For example work on developing, recognizing and appropriately responding to the feelings of others requires the emotional awareness and expression of the child's own feelings.

Social skill development often lends itself to complex multi-layered interventions. As indicated above, a level of emotional maturity is necessary for success. There is also the emotional development of the peer group to be considered.

Preschoolers are a very forgiving group socially, in that they are all learning social skills through trial and error. By grade two there is an emergence of the 'social group' that collectively continue to support learning but with each passing few months the expectation of the group for change of problematic behaviour increases. Therapists have long understood that their role in social skill work with their clients is very limited as social skills is an experiential process within the similar age group. By North American norms, grade 2, 3 and 4 students have expectations that sharing, turn taking and primary negotiating communication skills to resolve social conflicts are present. Staff support in social situations can be a very helpful addition for children that have used their sexualized behaviour as an engagement strategy.

With respect to caregivers, our primary intervention is education but often it is not the parent's knowledge that is the obstacle to change. In these situations, we would suggest parent participation in a consultation process with the intent of identifying the obstacles and inviting the parents into create a workable plan. Increasing the circle of support (e.g., calling upon extended families and communities) is an additional way of ensuring that support to both the caregiver and the child is present.

Conclusion

We hope you have found the information and examples contained in this publication helpful. As you are probably aware, the more work you do in this field, the easier it will become. The knowledge base will be internalized, the comfort with the topic will increase and your ability to join a child and his/her family/caregivers where they are at will improve. Just as we are challenging these children and families to learn new skill sets and approach their problems in different ways, we too must to endeavor to do the same.

We invite your feedback on this publication and on your experience using the Sexualized Behaviour Treatment Worksheet. Please contact the authors Heather Barbour of the Halton Trauma Centre (Oakville, Ontario) and/or Karen Holladay of the SAFE-T Program, Thistletown Regional Centre (Etobicoke, Ontario) with your feedback.

Thank You.

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Sexualized Behaviour Treatment Worksheet

Targeted Behaviour:	
Current Meaning and Function of Behaviour:	
Research Directives:	

Developmental Factors

Cognitive: ____________________
Emotional: ____________________
Behavioural: ____________________
Physiological: ____________________

Learning Profile (to match intervention to strengths)

Auditory 1-------------------5------------------10
Visual 1-------------------5------------------10
Kinesthetic 1-------------------5------------------10

Identified Challenges: ____________________
Identified Strengths: ____________________

Target Audience

____Individual _____Caregiver(s) _____Community

Treatment Interventions:

Psychoeducation:
Interventions with Child:
Interventions with Others:
Practice Recommendations:

Required Supplies:
1.
2.
3.
4.

SAFE-T Program

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Both are agencies dedicated to improving the lives of children and their families and to contributing to the education of professionals working in the field of sexual abuse.