

The Sexual Behaviors of Children:

What is Normative v. What is Problematic

How We Can Best Help Children

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Biography



Stefanie is an LPC-MHSP licensed in Tennessee and Vermont (telehealth). She is currently a Clinical Therapist and the Professional Development & Training Coordinator for Sexual Assault Center (SAC) here in Nashville. About half of Stefanie’s caseload consists of children and teens and about half consists of adults. Stefanie specializes in complex trauma with a “bottom-up” approach to treatment, with emphasis on somatic and experiential techniques including play, sandtray, art, movement, mindfulness, and meditation to enhance and supplement any structured modality. Stefanie has extensive training in EMDR, TF-CBT, TIST, ARC, and Play Therapy. Prior to joining SAC, Stefanie was a school-based therapist for two elementary schools and then a primary therapist at a juvenile justice facility for youth with mental health diagnoses.

Disclaimer

All of the material presented in this presentation was compiled by Stefanie R. Golper and may not be the standard of care for all Sexual Assault Center (SAC) clients now or in the future. All of the opinions expressed are solely those of Stefanie R. Golper and do not represent SAC or any part thereof.

Trigger Warning

This presentation includes frank discussions of children and sexuality, child sexual abuse, and parts of the body.

Overview

- Definitions and Language Used
- Normative Sexual Behavior and Normative Childhood Sex Play
- Problematic Sexual Behavior in Children
 - Myths v. Facts
 - Prevalence
 - Contributing Factors
- Treating the Child
 - Diagnostic Considerations
 - Assessment
 - Best Practices
 - Treatment Models and Modalities
 - Caregiver Involvement

Definitions and Common Language Used

❖ Child:

Chronological age of 0 to 12 years old.

❖ Youth or Adolescent:

Chronological age of 13 to 18 years old.

❖ Normative Sexual Behaviors:

Behaviors that involve parts of the body considered to be “private” or “sexual” (e.g., genitals, breasts, buttocks, etc.) but do not rise to the level of being problematic.

❖ Private Parts:

Body parts that are generally considered to be “sexual”. This includes genitalia, breasts, and buttocks. When defining “private parts” to a child, one can call them the parts of the body that are normally covered by our swimming suits.



❖ Childhood Sex Play:

Children's play that involves exploring each other's bodies and roles. Sex play occurs between children of similar age, size, development, and abilities. The children typically know and play with each other regularly, such as siblings, other children in the family, neighbors, or friends, rather than among strangers. The children involved in sex play may be of the same or different gender. As children get older and more aware of the social rules, their sexual behavior, including sex play, becomes hidden and is generally not known to caregivers. Sexual play is periodic, by mutual agreement, and lighthearted.

❖ Intrusive Sexual Behaviors:

Behaviors that involved others, including animals, other children, or adults.

❖ Aggressive Sexual Behaviors:

Behaviors that: 1) persist after limits are set; 2) involve planning how to touch other children sexually; 3) include one child forcing others to engage in sex acts; and 4) include acts of physical penetration.

Why we use specific terminology

- Developmentally sensitive.
- Focuses on ***behavior(s)*** instead of labeling the individual.
- Term “sexually reactive behavior” implies that the behavior is solely ***in reaction to*** trauma. The term “problematic sexual behavior” acknowledges the possibility for multiple underlying causes.
- Terminology provides for a clearer clinical framework that behaviors may fall along a continuum.
- Separates non-criminal behavior from criminal behavior.
- Using words like “child perpetrator”, “child sex offender”, or “child sexual abuser” have been found to relate to harsher responses by community systems than terms that separate individual from the behaviors.

Myths and Facts

Common Misconceptions about
Problematic Sexual Behavior in Children

Adults should only worry about adult sexual behavior with children. Child-on-child behavior is not really a problem.

FALSE

According to a 2014 study of over 13,000 children and adolescents, for those who reported being victims of sexual assault or abuse, over 70% reported that the person who assaulted/abused them was a child or adolescent.

Children who were sexually abused are going to abuse other children.

FALSE

Most children who have been sexually abused **do not** have sexual behavior issues. But, children with PSB are more likely to have a history of child abuse.

Children with PSB grow up to be adult sexual offenders.

FALSE

According to the current research, there is no direct correlation between childhood PSB leading to continued behavior into adulthood. Furthermore, most adult sexual offenders do not report a childhood onset of behaviors. However, childhood PSB can directly lead to adolescent PSB.

Girls don't have PSB.

FALSE

Studies have shown that girls may represent anywhere from 33% to 65% of children with PSB.

Children with intrusive PSB should not live in a home with other children.

FALSE

With appropriate treatment and careful supervision, most children with PSB can live and interact safely with other children.

Without long-term, intensive therapy, children with PSB will continue to have sexual behavior issues.

FALSE

Treatment outcome research has shown that most children show significantly lower PSB after even short-term treatment, and the recidivism rates for children ages 6 to 12 \approx 15% after two years of treatment. In addition, the adolescent recidivism rate \approx 7-9%.

Normative Developmental Sexual Behavior and Normative Childhood Sex Play

Normative Sexual Behavior



Normative sexual behavior is like other childhood play...

It is usually *spontaneous*, and includes

pleasure

JOY

laughter

embarrassment

and varying levels of inhibition and exhibition.

Normative Sexual Behavior – Ages 2 to 4

A pre-school child typically displays a natural curiosity for all body parts and their functions, and private parts are understood as just an interesting part of a person's body.

Pre-school children tend to actively learn about the world through listening, looking, touching, and imitating. Sexual behavior often occurs in public and may include:

Touching or rubbing genitals

Watching or poking others' bodies

Showing interest in bathroom functions

Trying out inappropriate language about sex

Playing "house" including affection between partners

Playing "doctor" (exploring the body)

Touching an adult's breasts

Intruding on others' physical boundaries

Showing genitals

***** Dressing like the opposite gender, role-playing with gender roles, and gender explorations are not considered "sexual behavior". *****



Normative Sexual Behavior – Ages 5 to 7

As children enter school and there is an increase in interaction with others of similar age; they start to notice differences between boys and girls. School-age children become more social in their exploration and their behaviors may include:



- Intentionally touching their own genitals
- Showing more preference for privacy (inhibitions)
- Expressing dislike of the opposite sex
- Telling “dirty” jokes
- Playing “house”
- Kissing and holding hands
- Mimicking adult relationships
- Talking about private parts and using “naughty” language
- Seeking out information: watching others, asking questions, exploring electronic media

Normative Sexual Behavior – Ages 8 to 12

Girls can start puberty as early as 7 or 8, and boys usually start after age 10. In the pre-pubescent years, children’s awareness of social rules increases, and they become more modest, particularly around adults. Children are likely to hide their sex play or self-touch activities from their caregivers. Curiosity about adult sexual behavior increases and children may seek out sexualized content in the media.

Other behaviors may include:

- Purposeful self-touching in private
- Showing private parts (mooning/flashing)
- Exhibitionistic activities
- Attempting to see peers or adults naked
- Showing greater interest in “dating”
- Looking at images of nudity
- Showing affection to peers with kissing
- Playing games involving sexual behavior (like “Truth or Dare”)
- Teasing the person they are attracted to
- Beginning to show attraction to peers



- Wanting more privacy
- Choosing media with sexual content

Child self-touch is not the same as adult masturbation!



Children as young as seven months may touch and play with their own genitalia. The self-touch behavior of infants and young children appears largely to be related to their curiosity and seeking soothing physical sensations. From infancy on, children begin to explore the world. They learn about things that feel good and things that don't. Various parts of the human body have a high concentration of nerve endings which makes these areas very sensitive to touch. Children discover the sensitivities of their genitals during their normal exploration. Very early childhood self-touch of genitals is a similar activity to when a child sucks their thumb or snuggles with a soft blanket.

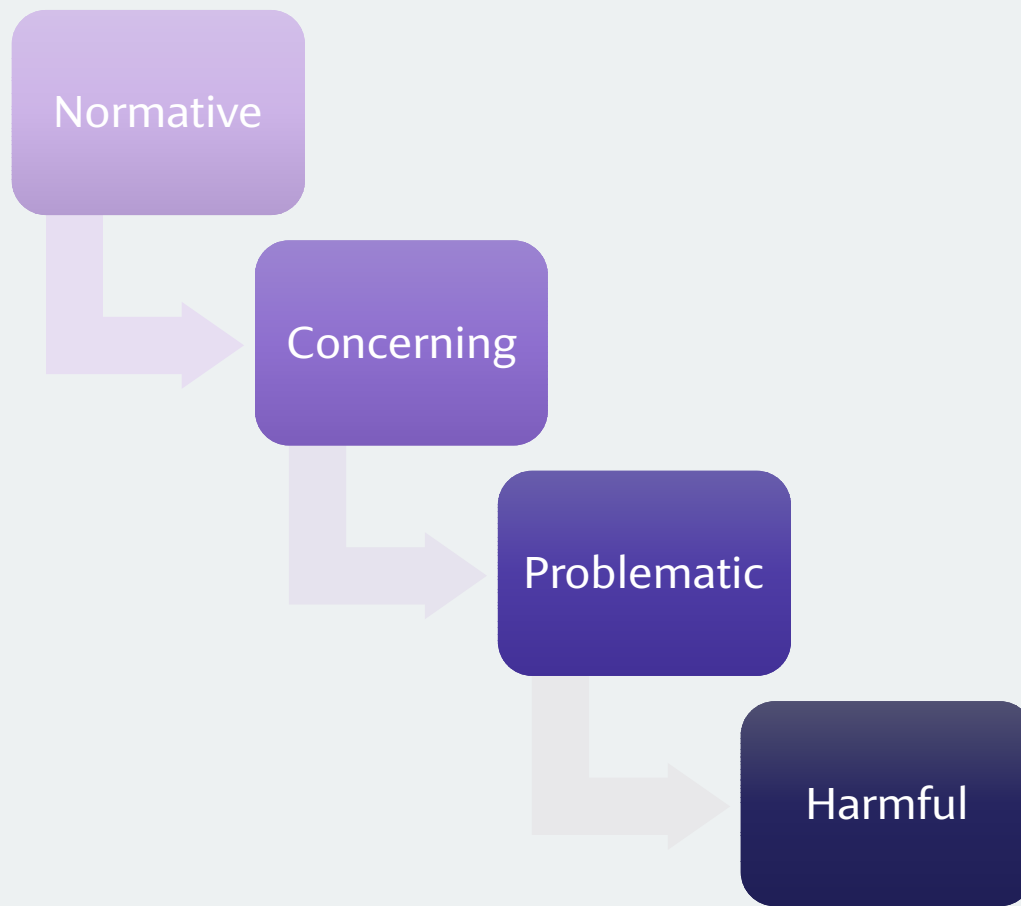
Even as infants, children are capable of sexual arousal. Newborn baby boys can have penile erections. It is an automatic body response, just like sneezing around pollen. This is **very** different from adult sexuality and adult self-stimulatory behavior. With young children, bodily responses are not a response to a sexual fantasy, it is just something that feels comforting or good.

Normative Sex Play

- Most sexual play is an expression of children's natural curiosity.
- Children's interest in sexuality gradually increases with age and development, just like physical, emotional, and intellectual development.
- Typical in siblings and good friends...usually within a two-year age span.
- Masturbatory behavior usually peaks around ages 3 to 5 years old.
- Normative sex play is voluntary (none of the children seem uncomfortable or upset).
- This type of play can be easily diverted when caregivers tell children to stop and explain privacy rules.
- Can include "playing doctor", teasing, showing each other private parts, pretending to be dating or married, holding hands, etc.
- Pretend play will increase in detail as children mature and get exposed to more information.



What is Problematic Sexual Behavior?



There is no clear line that separates normative from problematic. Sexual behavior in children falls along a continuum from normative, to cautionary, to harmful.

All troubling behaviors are to be assessed within the **context** of multiple factors, which may include:

- Age differences between the children.
- Power differentials between the children (including size, intellectual capabilities, neurodevelopmental capabilities, positions of authority).
- Behavior is associated with strong, upset feelings (anger, anxiety/fear).
- Potential for harm to any of the children involved (including any potential harm from self-stimulation behaviors).

PSB May Include

- Harmful or excessive self-touch or self-stimulation, such that it causes physical harm or damage, is excessive, and/or occurs in public despite interventions.
- Non-intrusive and repetitive sexual behaviors, such as preoccupation with nudity, surreptitiously looking at others when they are naked, frequently showing private parts to others, preoccupation with pornography (especially child sexual abuse images or violent media), sexting, and/or offensive sexualized language.
- Sexual touching without permission or consent, such as poking, rubbing, or squeezing.
- Sexual interactions with others which are developmentally inappropriate and/or illegal, such as digital-genital contact, oral-genital contact, and/or sexual behavior that involves penetration.
- Distributing child-produced sexual images, such as through text or social media.
- Sexual contact with animals.
- Coercive or aggressive sexual contact or penetration.



Questions a Caregiver May Consider When Comparing Their Child to Peers

- ✓ Does my child seem to have more interest in this area?
- ✓ Do other children complain about what my child is doing?
- ✓ Is there a significant age difference between my child and the other children they are playing with?
- ✓ Does it seem like one child has power over the other?
- ✓ Does the behavior seem aggressive or forceful?
- ✓ Is it difficult for me to distract my child from this behavior, or is my child not responsive to redirection?
- ✓ Does the sexual play seem overly focused, exclusive, frequent, or intense?

Prevalence and Research



Onset of PSB may occur at age 3 or 4.

Girls appear more likely than boys to exhibit PSB during preschool years.

Boys are more likely to exhibit PSB during the elementary and middle school years.



Gender does not make a difference in the type of PSB exhibited.

Intrusive PSB often occurs with children in close proximity. Children usually choose to involve those close to them, regardless of gender.



PSB with children who are strangers is rare.

There is no pattern of demographic, psychological, or social factors that distinguish children with PSB from other groups of children.



There are no qualitatively different subtypes of PSB, but there are varying degrees of severity and intensity of PSB overall.

More frequent and intrusive PSB tend to also have co-morbid issues.

Possible Contributing Factors



Environmental Factors:

- Exposure to traumatic experiences, especially child maltreatment.
- Exposure to violence in the home, including coercive or neglectful parenting.
- Excessive exposure to adult sexual activity or nudity in the home (including media exposure).
- Inadequate rules about modesty and privacy in the home.
- Inadequate supervision in the home.
- Heredity.

Behavioral Factors:

- Impulsiveness and a tendency to act before thinking.
- Difficulties following rules and listening to authority figures.
- Problems making friends their own age and tendency to play with much younger children.
- Limited ability to self-soothe.
- Problems with emotional dysregulation.

Other Factors:

- Development adversity and/or neurodivergence.



But Why?



There are many possible reasons why children may show sexual behaviors that are inappropriate or unexpected for their age. In general, children's sexual behavior problems are **rarely about sexual pleasure.**

In fact, these behaviors are much more likely to be related to *anxiety*, *traumatic experiences*, *curiosity*, *poor impulse control*, or other factors.

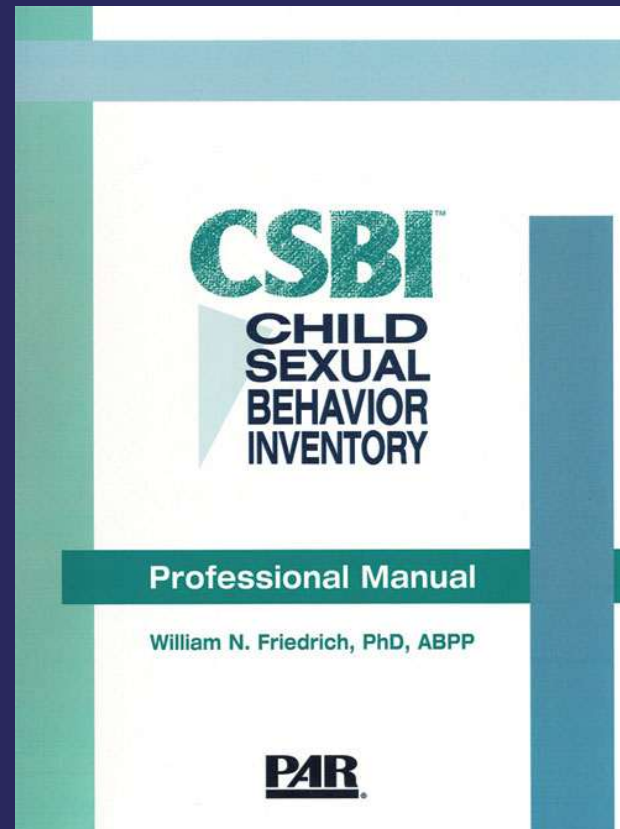
** Images from "Broken Crayons" art exhibition in 2017 by Amigos for Kids (<https://brokencrayons.us/>) **

Treating the Child

Treating the Child

Diagnostic Considerations, Assessments, and Best Practices for Treatment

5/30/2026



The Sexual Behaviors of Children

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Diagnostic Considerations

PSB are not diagnosable conditions. Instead, they are clinically concerning behaviors. Sometimes, the behavior is isolated, but other times, the behavior is part of a pattern of disruptive behaviors.

Consider these factors:

- ✓ Are these behaviors a symptom of other disruptive behavior disorders?
- ✓ Does this child have a history of trauma, especially sexual abuse with one or more of the following?
 - abuse started before pre-school age
 - abuse involved penetration
 - abuse involved multiple perpetrators
 - abuse occurred frequently
- ✓ Are any of the children involved diagnosed with learning disabilities, developmental disabilities, or neurodivergence?

Assessing if the Child Needs Specific PSB Treatment

There is no standard assessment professionals use to determine if the child's behavior rises to the level where specific PSB treatment is needed.

If PSB is suspected, clinicians should take the following into consideration:

- Only assess for specific PSB if the child's sexual behaviors have caused concern with the caregivers, the school, or an outside agency.
- Social and cultural context of the behaviors.
- Environmental factors.
- Family dynamics, including whether there is consistent and empathetic supervision in the child's immediate environment.



Components of PSB Clinical Assessments

A clinician assessment should include the following components:

- 1) Intake interviews with caregiver(s), with child, and together;
- 2) History of type, frequency, duration, severity, and onset of the behaviors. Also noting how the behaviors have been addressed to date, and the child's responsiveness to adult interventions;
- 3) Use of the CSBI or ASB-C along with a behavioral measure such as the Behavioral Checklist for Children (BASC) or the Child Behavior Checklist (CBCL);
- 4) Use of a trauma measure if a trauma history is known or suspected; and
- 5) Assessment for co-occurring concerns such as other internalizing symptoms, disruptive behavior disorder symptoms, social skills deficits, and learning difficulties.

Child Sexual Behavior Inventory (CSBI)

- ❖ Developed to both establish a baseline of normative behaviors and to evaluate when sexual abuse is suspected.
- ❖ For children ages 2-12.
- ❖ 38-item inventory of statements regarding the child's behavior over the previous 6 months.
- ❖ Completed by a caregiver who responds with *Never*, *Less than 1/month*, *1-3/month*, or *At least 1/week*.
- ❖ Yields scores in these areas:
 - Total CSBI score scale indicates whether totality of behaviors are to be considered clinically significant and warrant further investigation.
 - Developmentally Related Sexual Behavior (DRSB) scale indicates sexual behaviors that can be considered normative for the child's age and gender.
 - The Sexual Abuse Specific Items (SASI) scale indicates sexual behaviors that can be viewed as relatively atypical for the child's age and gender; such behaviors raise the suspicion of possible sexual abuse.
- ❖ Purchased through PAR.

Assessment of Sexual Behavior – Children (ASB-C)

- ❖ For children ages 3-12.
- ❖ 36-item inventory of statements regarding the child's behavior over the previous month.
- ❖ Completed by a caregiver who responds with *Never, Once, 2-4 times, 5-10 times, or More than 10 times*.
- ❖ Asks if the behavior involved anyone else.
- ❖ Asks where behavior occurred.
- ❖ Has separate norms for age and gender.
- ❖ Yields scores that fall into: Typical/Expected, Concerning, and Problematic.
- ❖ Free and available online.

Treatment Planning



When choosing the appropriate treatment planning options, consider that most children with PSB can be broadly grouped into the following categories:

- Children with PSB only
- Children with disruptive behavior disorder symptoms and PSB
- Children with PTSD or other trauma-reactive symptoms and PSB
- Children who have complicated trauma histories and clinical presentations with a combination of PSB, PTSD, and disruptive behavior disorder symptoms

Best Practices for PSB Treatment for Children



- ❖ Developmentally appropriate
- ❖ Evidence supported: Cognitive-behavioral, skills-based, and multi-systemic approaches that involve caregivers have shown the best outcomes. No medication has been shown effective.
- ❖ Trauma informed
- ❖ Family focused: Most effective evidence-based strategies actively involve the caregivers in treatment and address supporting the caregiver's application of effective strategies to manage the child's behavior.
- ❖ Least restrictive possible: Higher level of care options should be reserved for those 13 and over and only those children whose behavior causes considerable risk to self or others.
- ❖ Minimization of false assumptions: While a child may be exhibiting adult-like sexual behavior, it does not necessarily mean that they have been abused sexually or that they are on a path to life-long sexual aggression.

Treatment for PSB Should Include

- Naming of Body Parts: proper terms (e.g., anus not buttole) and their function.
- Discussion and Establishment of Boundaries: physical, emotional, and intellectual/psychological.
- Differentiating Public Behavior v. Private Behavior
- Discussion of Touching: different types of touching, appropriateness of touching, touching self, and touching others.
- Discussion of Shame: including the difference between shame and guilt.
- Awareness of Emotions: naming, knowing, and expressing emotions along with learning “why” feeling a certain feeling and the stressors that trigger dysregulation.
- Developing Coping Skills and Self-Control Strategies
- Education about Sexual Development and Healthy Sex Play/Exploration
- Developing and Practicing Social Skills
- Flexibility and Awareness of the Social Ecology of the Family: treating the child as a part of the family system.

Safety Considerations

At all times during the clinical decision-making process, **safety for all** should be the top priority.

Safety of siblings or other children in the home:

Other children in the family home may experience fear or concern for their sibling which can manifest as stress responses.

If separation is necessary, consider timing, visitations, and a plan for reunification.

If the child acted out with the siblings, more intensive treatment may be warranted and the sibling(s) will most likely need their own treatment for child sexual abuse.

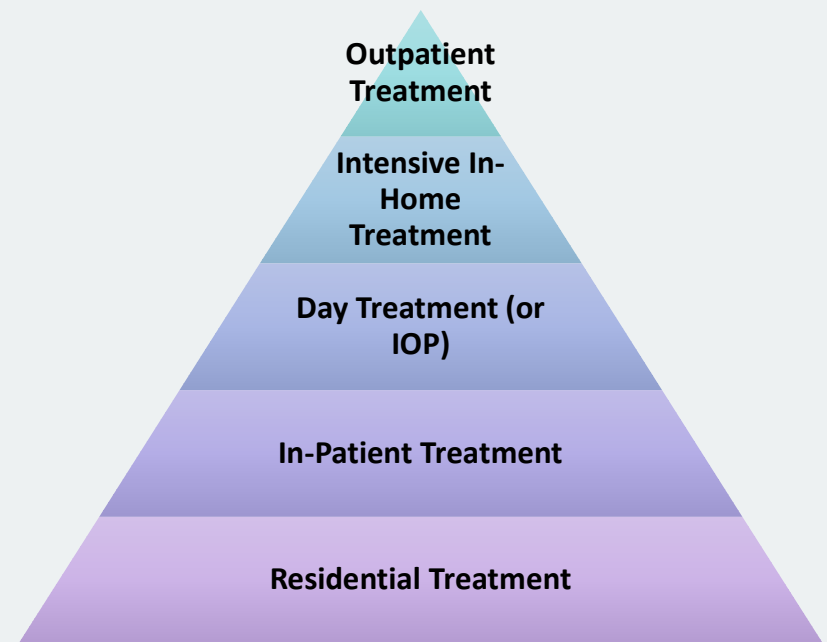
What if it is not safe for the child to remain in the family home? Before opting for community placement, consider alternative placements like with extended family, kinship care, or foster care.

Implement safety plans for home, school, in public, and in the therapy spaces.

Level of Care Considerations

A continuum of care and placement options are needed that flexibly meets the needs of the child with PSB, the siblings or other children in the home, and the caregivers. Interventions should be no more restrictive than what is needed for community safety and the child's well-being. Most children with PSB can remain in the community.

If there is no DCS or juvenile justice involvement, the level of care is to be determined by the family, however some private care can be costly and may not be covered by health insurance.



When to Consider a Higher Level of Care?

- If the child cannot remain in the home and the child has no other family options.
- If the behavior has led to DCS and/or juvenile justice involvement and a higher level of care has been determined necessary.
- If the behavior is severe and remaining in the community could cause harm to the child or to others.
- If there are co-occurring mental health issues such as severe psychiatric disorders or suicidal or homicidal ideation.
- If there are other issues (e.g., other behavioral problems, instability in the home, substance use) which call for increased intervention.



Treating the Child

Treatment Models and Modalities



Treatment Models & Modalities

Problematic Sexual Behavior Cognitive Behavior Therapy (PSB-CBT)

- Ages 7-12
- Concurrent groups of children and caregivers with combined multi-family group interactions
- Active participation of caregiver(s) required
- Strengths-based, focusing on child having capacity to learn and implement appropriate behavior, make safe decisions, and develop healthy relationships
- Uses CBT approaches that teach rules about sexual behavior and specific skills of coping, self-control, and decision-making
- Core treatment components with caregiver(s) address managing child behavior, supporting healthy development, sex education, abuse prevention, and rules around sexual behavior
- Commitment for 18 weekly group sessions

Treatment Models & Modalities

Trauma-Focused Cognitive Behavior Therapy for Trauma-Related Problematic Sexual Behavior (TF-CBT PSB)



- Ages 3-12
- Family or group
- Caregiver involvement emphasized but not required, but especially encouraged when treating trauma-related PSB
- TF-CBT model with enhanced caregiver training to prevent and respond to PSB, establishing rules and boundaries around sexual behavior, increased family safety planning, implementation of impulse-control and problem-solving skills, and developmentally-appropriate sex education.
- 8-20 weekly sessions

Treatment Models & Modalities

Parent-Child Interaction Therapy (PCIT)

- Ages 2-7
- Didactic sessions using a transmitter and receiver system
- Utilizes components of attachment theory, social learning theory, behavior modification, and systems theory
- Stage One focuses on the caregiver learning relationship-building skills and receiving live coaching and feedback as those skills are practiced with the child in session while the therapist is coaching from behind a one-way mirror
- Stage Two focuses on teaching and coaching the caregiver in a positive discipline program
- Skills developed in both stages are gradually expanded for use in structured home setting to unstructured home setting to public settings
- 14-25 sessions

Treatment Models & Modalities

SMART (Safety, Mentoring, Advocacy, Recovery & Treatment) Model

- Ages 3-11
- Individual, family, and group
- Structured, phase-based approach
- Incorporates CBT practices along with psycho-education and skill-building
- Specific considerations for cultural or community aspects and group experiences, including: family power structures, perceptions regarding sexuality and gender roles, conflicting identities, stigmatization of mental health, and spirituality
- 12 months which include: 34 individual sessions, 40 family sessions, and 24 group sessions



Treatment Models & Modalities

The Boundary Project

- Ages 4-12
- Concurrent groups of children and caregivers with combined multi-family group interactions – can also be tailored for individual and family sessions
- Structured family-focused curriculum that integrates CBT with expressive therapy techniques
- Maintains a contextual understanding of the impact of trauma on child development, the various ways that children experience and attempt to resolve their traumas, and invites children's participation and investment in their own therapy
- Requires full participation by caregivers and includes weekly homework for children, caregivers, and for the family
- Incorporates use of mindfulness, play, sandtray, and art therapies
- 12 weekly sessions



Treatment Models & Modalities

Multi-Systemic Therapy for Youth with Problematic Sexual Behavior (MST-PSB)

- Ages 10-17
- Implemented in child's home or community setting and includes individual and family sessions
- Incorporates intensive family therapy, CBT, skills building, and school and community system interventions
- Includes focus on child and/or caregiver denial regarding PSB, strengthening positive parenting, increasing child and caregiver knowledge regarding PSB, encourages familial affection and communication, enhances problem-solving skills, and enhances appropriate social skills and relationships with peers
- Supports children returning to home/community from incarceration or residential placement
- 5-7 months of three home visits per week

Treating the Child

Caregiver Involvement in Treatment Process



Caregiver Involvement in Therapy Spaces

The purpose of family sessions are to:

- Rebuild trust within the family dynamic, including honest conversations and transparency
- Enhance emotional awareness and regulation
- Clarify boundaries moving forward
- Allow for apology and empathy
- Address crises, complex, and/or concurrent problems with all those involved
- Practice behavior management skills
- Enhance attachment between child and caregiver(s) and allow for repair of any attachment ruptures



Therapy “Homework”

While different treatment modalities may involve differing levels of caregiver involvement, most modalities include activities, exercises, or “homework” for the child, caregiver(s), or family to do outside of the therapy spaces. Homework may include:

- Teaching sex education to all of the children in the home while practicing how to listen and talk with children about sexual matters.
- Focusing on parenting strategies to build positive relationships with the children.
- Supporting child’s use of self-control/coping strategies.
- Expressing appropriate affection within the family, with peers, and with adults.
- Guiding children toward positive peer groups.
- Enhancing supportive, positive, and mutually-enjoyable interactions among family members.

Caregiver Involvement at Home

Along with homework, the caregiver(s) should initiate regular “family talks”. Family talks can have many purposes. Some may include:

- A space where family members can talk openly, without repercussions, about thoughts or feelings they have that might be worrisome or confusing.
- Caregiver(s) can bring up sex-positive messaging. These are messages that the caregiver(s) have developed beforehand and are statements that are comfortable for the caregiver(s) to say with conviction. For example, “sex is something that grown-ups do to show their love for each other”. This allows for discussion on positive topics where the focus is not on the “problem”.
- Establishing fun or positive activities that the family can do together.



Establishing Family Rules

All family rules should include some aspect of the following:

- ✓ It is not OK to show your private parts to others.
- ✓ It is not OK to look at other people's private parts.
- ✓ It is not OK to touch other people's private parts.
- ✓ It is OK to touch your private parts as long as it is in private and does not take too much time.
- ✓ It is not OK to use sexual language or make other people uncomfortable with your sexual behavior.



Other Ways Caregivers Can Help Children with PSB at Home



- Finding something positive to say to the child everyday. This can boost their self-esteem.
- Recognize what they do well and provide small rewards for reaching goals.
- Instead of just focusing on when the child does something **wrong** or **bad**, catch the child being **good** or **doing well**.
- Be a role model in being trustworthy. Show that they can trust you so you, in turn, can trust them.
- Use consistent language, including the proper names for body parts, and be consistent in consequences for problem behavior.

Remember

These are **CHILDREN**.

Like children with other behavioral issues, the clinical focus is on improving and changing the behavior within the context of affirming, supporting, and validating the child for who they are. The well-being of the child, the family, and the community should be at the center of what we do.



What there is still to learn...

or... what this presentation didn't cover

Treating the Caregiver(s)
“What do I do now?”
Caregiver Self-Care

Treating the Family
Working with Siblings
Sibling-on-Sibling PSB

Treating Adolescents

Treating Special Populations
Intellectual Disabilities/Cognitive Impairment, Neurodivergence, and Other Disabilities

Implications of Behavior
School
Legal Challenges
Involvement of DCS and Other Entities

Questions

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Resources & References

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asta.com

The Boundary Project (Eliana Gil) -
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National Children’s Alliance (NCA) –
nationalchildrensalliance.org

The National Child Traumatic Stress Network (NCTSN) – nctsn.org

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