CHILDREN WHO MOLEST CHILDREN

IDENTIFICATION AND TREATMENT APPROACHES FOR CHILDREN WHO MOLEST OTHER CHILDREN

—by Toni Cavanagh Johnson

Do Children Molest Other Children?

Despite the increasing numbers of young offenders being reported for serious sex offenses, professionals involved with the care and protection of children find it difficult to accept that children twelve years and younger can molest other children (Alberton, 1990; FBI, 1990; Peyser, 1989). The general response from some police, protective services, and mental health professionals is that the behaviors of these "child perpetrators" (Johnson, 1990b) is just sex play. This is akin to the response in the 1970's and early 1980's when the sexually coercive behaviors of adolescents was becoming more evident.

During the 1980's numerous studies of adolescent sexual behaviors encouraged a thoughtful look at the range of sexual behaviors in this age group (O'Brien, 1985). Studies by Judith Becker, and others documented the seriousness of the sexual offenses committed by adolescents (Becker, Cunningham-Rathner, & Kaplan, 1987). These studies yielded a better understanding of the problem of adolescent sex offending and a concomitant rise in the number of treatment programs for this population. In the early 1980's there were fewer than 20 treatment programs for adolescent sex offenders; today there are over 600.

As with adolescent sexual behaviors, the sexual behaviors of children twelve and younger must be studied and criteria developed to aid in the proper assessment and treatment of young children whose behavior is sexually abusive. This process will stimulate the development of treatment programs specifically for children who molest, of which there are only a handful in the country.

A Continuum of Sexual Behaviors

Over the last six years it has become evident that the problem of children acting out sexually is highly complex and requires very detailed evaluation. After evaluating and consulting on hundreds of children who were referred due to sexual acting out behaviors, four definable groups of these children have been identified. Group I includes children engaged in normal childhood sexual exploration, Group II is composed of sexually-reactive children, Group III includes children mutually engaged in the full range of adult sexual behaviors, and Group IV includes child perpetrators. This model applies to boys and girls twelve and under who have intact reality testing, are not mentally retarded, and are engaged in sexual behaviors. Each group includes a wide range of children, with some children on the borderline between groups, and others moving between groups over time. The most divergent, groups I and IV, will be described first.

Normal Sexual Exploration	Sexually-reactive	Extensive Mutual Sexual Behavior	Child Perpetrators
Group I	Group II	Group III	Group IV

A Continuum of Sexual Behaviors from Normal to Deviant

Group I - Normal Childhood Exploration

Normal childhood sexual exploration is an information-gathering process wherein children visually and tactually explore each other's bodies, as well as try out gender roles and behaviors (e.g., playing house). Children involved in normal sex play are of similar age and size, generally of mixed sex, and are friends rather than siblings, and they participate on a voluntary basis (Finkelhor, 1979). The affect of the children regarding the sexual behavior is light-hearted and spontaneous. Normal sexual exploration may result in embarrassment but does not usually leave children with deep feelings of anger, shame, fear, or anxiety. If children are discovered in sexual exploration and instructed to stop, the sexual behavior usually diminishes or ceases, to arise again during another period of the child's sexual development. The sexual behaviors are limited in type and frequency. The behaviors engaged in typically include autostimulation and self-exploration, kissing, hugging, peeking, touching and/or exposing genitals to other children, and, perhaps, simulating intercourse (Goldman & Goldman, 1988). Two or three percent of children twelve and younger actually engage in intercourse (Haugaard & Tilly, 1988). The range of sexual behaviors in children is wide: some children will engage in all of the behaviors described above, some children may engage in none, or only a few. There are differences due to the developmental level of the child, the child's level of interest, and the amount of exposure the child has had to adult sexuality, nudity, and explicit television and videos. Parental and societal attitudes and values, as well as the child's peer group and living conditions, also influence the types and range of the child's behaviors.

The sexual behavior of children engaged in the normal process of childhood curiosity is balanced with exploration of other parts of their universe. They want to know how babies are made as well as why the sun disappears. They want to explore the physical differences between males and females as well as figure out how to get their homework done quickly so that they can play.

Group IV - Molestation Behavior

The balance of sexual interest and behaviors in normal childhood development is not present among child perpetrators. These children's thoughts, fantasies, and actions are often pervaded with sexuality. The sexual behaviors, attempts to experiment with or play out these thoughts and fantasies, continue and increase over time; they are not isolated to a few instances or discrete periods of the child's life. The child perpetrator engages in a wide range of sexual behaviors with many children, including siblings. Their behaviors tend to be secretive and manipulative. When child perpetrators are told to stop, they do not, and cannot without professional help.

In many of the children, the sexual acting out is impulsive, compulsive, and aggressive. The child perpetrator is highly confused and anxious about sex and sexuality. Many of these children directly associate feelings of aggression, anger, and sometimes even rage with sex. Others associate sex with feelings of loneliness, fear, or abandonment. Overexposed to sexuality, often to deviant and pathological sexuality such as promiscuity, pornography, incest, and sexualized violence, these children no longer have the normal curiosity of young children.

Child perpetrators seek out children whom they can coerce, fool, bribe, or force into sexual activity with them. The victimized child is not mutually involved in decisions about what the sexual activity will be or when it will end. In sibling incest, when the perpetrator is a boy, the victimized child is often the favored child of the parent/s. In other cases the child is selected due to special vulnerabilities, such as age, intellectual impairment, extreme loneliness, depression, social isolation or neediness. These children often use threats to keep their victims from telling. "I won't play with you ever again, if you tell," said to a child victim abandoned by his parents is a powerful reason to keep quiet. A child perpetrator will engage in coercive sexual behaviors with older, younger, or same age children. The age difference between perpetrator and victim may be as great as twelve years, because some of these children molest infants. The sexual behaviors of these children include peeking, exposing, kissing and hugging, penetration of the vagina or anus of another child with fingers and/or foreign objects, oral sex, vaginal and anal intercourse. Some of the victims suffer physical trauma. Child perpetrators will continue to engage in these behaviors even after harsh punishment.

Some child perpetrators also show a vast array of other behaviors that may not at first appear sexual but are related to their sexual difficulties. Focused on the genitals, these behaviors tend to revolve around

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toileting. Virtually all child perpetrators have behavioral problems at home and at school and have very few friends. These children are frequently physically as well as sexually aggressive, have very limited problem solving and coping skills and little impulse control (Friedrich & Luecke, 1988).

Approximately 25% of child perpetrators are female. In a study of 13 girl perpetrators, ages 10 and under, all had been sexually abused (Johnson, 1989). Approximately 60-70% of boy child perpetrators have been sexually abused. Generally, the abuse is not recent but has occurred years prior to the start of their sexually aggressive behaviors. Many of the children have been physically maltreated. Virtually all of these children have lived in environments that are overtly sexually stimulating, with caretakers who themselves demonstrate extreme emotional confusion, poor impulse control, and little awareness of how their own sexuality and dependency needs affect their children. Most of the parents fail to maintain appropriate boundaries between themselves and their children when it comes to sexually explicit conversations, experiences, and behaviors. Sexual abuse, as well as physical and subtance abuse, is found in the nuclear and extended families of the children. Almost all of the children have witnessed extreme physical violence between their primary caretakers.

Group II - Sexually-reactive

Many children display sexual behaviors more extensive than those found among Group I children but not as extensive or aggressive as those of child perpetrators. Children whose repertoire of sexual behaviors exceeds what is expected for their age (Johnson, 1991a; Johnson, 1991b) can be described as "sexually-reactive" (Group II). Many children in Group II have been sexually abused. Other children in the group have been exposed to pornography, or have lived in households where there was too much sexual stimulation. Young children who watch excessive amounts of soap operas or cable television and videos and who live in sexually explicit environments may display a multitude of sexual behaviors. Many children who have been overstimulated sexually cannot integrate these experiences in a meaningful way. This can result in a child acting out the confusion in the form of more advanced or frequent sexual behaviors than would be expected for a child of that age. The behaviors may include but are not limited to exposing themselves, touching other children's or adults' private parts, imitating intercourse with other children, dolls and stuffed animals; self stimulating with hands and other objects, talking about sex acts; and displays of affection and interest in adults with whom the child is unfamiliar (Friedrich, Grambsch, Broughton, Kuiper, & Beilke, 1991)

Children in Group II may feel some shame or guilt and confusion but they do not display the level of anger and aggression in connection with sex and sexuality that a child in Group IV does. Many of these children's sexual behaviors involve only their own bodies. If they do engage in sexual behaviors with other children, the difference in age is usually not great and they do not force other children into sexual behaviors with them. Group II children are not seeking out children to coerce and victimize and do not threaten other children into silence. The sexual behaviors of these children often represent a recapitulation (often unconscious) of the previously overstimulated sexuality. The time between the sexual overstimulation and the sexual acting out is close, often overlapping or contiguous. The sexualized behavior can be seen as a working through of the confusion around sexuality. After being told, the children acknowledge the need to stop the behaviors and accept help. The sexual behaviors in this group of children are often fairly easy to stop as they do not represent the long pattern of secret, manipulative, and highly charged behaviors commonly found among child perpetrators. Interventions include openly discussing confusion around sexuality/sexual abuse, teaching the child boundaries, and helping the child's caretakers manage the behaviors and structure the living environment to decrease sexual stimulation.

Group III - Extensive Mutual Sexual Behaviors

A third group of children are those who engage in ongoing and extensive sexual behaviors, including oral sex and vaginal and anal intercourse, without apparent guilt, shame, or confusion. Anxiety related to the sexual behaviors is not evident and there is little desire to stop. In most of these children the sexual activity appears to be a way of life and a way of relating to peers. Between the children there are no offenders and no victims. Some persuasion but no force or emotional or physical coercion is used. They conspire together to engage in the sexual behaviors without the knowledge of adults. The children are generally within the same age range. Most of these children have been sexually abused by an adult, adolescent or child prior to this extensive mutual sexual contact with other children.

There are subgroups within Group III. Some Group III children have been sexually abused in a group and then continue the sexual behaviors with one another after the abuse stops. Others are siblings who mutually engage in extensive sexual behaviors as a way of coping in a highly chaotic and/or sexually abusive or dysfunctional family life. Some siblings, those who have been removed from their home repeatedly and placed in multiple foster care situations, cling to one another in this sexual way due to their feelings of fear and loneliness. These extensive mutual sexual behaviors are also seen in unrelated children in foster or residential care who may have begun as Group II children and progressed in the group living situation. This may involve many children at the same time.

Some of the children in Group III move between Group III and Group IV, i.e. betweeen mutually engaging in sexual behaviors and forcing or coercing another child into sexual behaviors.

Assessment

Children who have difficulty in the area of sexuality and sexual acting out need to be evaluated by a mental health professional who specializes in sexual abuse. Although the child may not have been sexually abused, sexual acting out is often a symptom of previous or current sexual abuse and should be considered. Initial assessment to determine where on the continuum the child falls will include:

- -an evaluation of the number and types of sexual behaviors of the child (Johnson, 1990a);
- -a history of the sexual behaviors;
- -whether the child is being sexual alone or with others;
- -the motivation for the sexual behavior;
- -the other child/ren's description, response and feelings regarding the sexual behavior;
- -the child's emotional, psychological, and social relationship to the other children involved;
- -if any trickery, bribery, physical or emotional coercion is involved;
- -the affect of the child regarding sexuality;
- -a thorough developmental history of the child, including abuse and out-of-home placements;
- -access and careful reading of reports to protective services, court reports, probation documents;
- -an assessment of the child's school behavior, behavior at home, behavior at out-of-home activities, such as day care or recreational programs, and peer relations;
- -a history of each family member, the family history and an evaluation of the emotional and sexual climate in the home. Assessment of these areas helps determine if the child falls in Group I, II, III, or IV.

Interventions

Although children in groups II and III need specific types of interventions, discussion of these is beyond the scope of this paper. Interventions for Group IV children include: reporting the behaviors to protective services and the police, collaborating with these agencies to assess the needs of the child regarding placement, evaluating the safety of the child and other children with whom the child comes in contact (school, home, neighborhood), working with the dependency and criminal courts, and providing treatment.

Individual, family, and group therapy are all important to the treatment plan for children who molest other children and their families. Additionally, behavioral, supportive, and protective interventions for the children must be planned with the family, school personnel and at other out-of-home activities. Therapeutic intervention with these children must be specific and focused on the child's problems. Therapy which does not

deal directly, and in an ongoing manner, with the sexual and aggressive issues is not useful to these children. For a more thorough description of a specialized treatment program for children who molest see the author's paper on SPARK, the Support Program for Abuse-Reactive Kids (Johnson & Berry, 1989).

Group Therapy. Emphasis is placed on group therapy due to the nature of the dysfunction of these children. Although they have intrapsychic pain and confusion that must be attended to, these children have chosen to act out this pain in an interpersonal manner. To treat the problem, its interpersonal aspects must be addressed directly. The group format allows the therapists to use the group members to help each other understand and work on their "touching" problems. The aim is to help the children interact with other children without being sexually or behaviorally inappropriate. The group mimics the school and neighborhood environment where these children have great difficulty interacting with other children. The process of the group involves "in vivo" learning. The anxiety, confusion, and shame associated with the sexual acting out is attenuated using the group format. The children feel better knowing that other children have the same problem and are working on it. The group format is very helpful in diffusing the tension and overcoming the difficulty of sustaining discussions about sexuality and the sexual acting out behaviors (Johnson, 1990b) The misinformation and distortions in the children's thinking are more readily available due to the group discussions and interactions. Working in a group the children are helped by recognizing their own denial and minimization of the sexual acting out by identifying and confronting it in the other children. Understanding the feelings and confusion of the other children regarding sexual acting out helps the children understand themselves better. Male-female cotherapy teams can provide a model for positive interactions between males and females which are lacking in the lives of these children.

Separate but parallel therapy groups for the parents, siblings/victims and nonabused siblings are very strongly recommended.

Family Therapy. The development of the sexual dysfunction of child perpetrators is heavily influenced by the environment in which the child lives and the persons who raise the child. If it has been determined that the child perpetrator can remain at home, extensive intervention with the family is essential. If the child has been removed to a group home, residential facility or the home of another family member (where there is adequate supervision and no vulnerable children), the child's surrogate family should be involved in the therapy. It is very important that either child protective services or the juvenile courts provide the authoritative incentive for the child and family to attend treatment.

Of initial importance is to assure that between family members there is clarity and openness regarding the child's sexual behaviors, understanding that it is a serious problem, and that all family members can help the child stop the behavior. Next, comprehensive plans must be made to help the child. These includes:

-identifying the precursors to the child's sexual acting out. These may be feelings of the child in certain situations, words or actions by family members, or other aspects of the child's environment, such as movies, videos, etc.
-planning to alter the situation to eliminate these stimuli.
-planning constructive and consistent responses to the child's sexual behaviors, including distractors and activities to which the child can be redirected.
-identifying the family members to whom the child should go for support and redirection when he/she feels like acting out sexually.
-determining the consequences for sexual acting out.
-agreeing on rewards for no sexual acting out;
-agreeing on any restrictions for the child, such as not being alone, bathing, changing, or sleeping with other children.

These plans should be clear, explicit, and written. Every week there should be discussion regarding problems, successes, and necessary modifications.

The child perpetrator must not be isolated as "bad"; instead the emphasis is more that the child is manifesting some of the problems in the family. It should be anticipated by the therapist and the family members that many other problems will need to be worked on in these sessions to help the child and the family. All issues related to sexuality and aggression, overt or covert, must be discussed. The family history and interactional patterns for several generations provide key insights into the current problems of the child. Previously undisclosed abuse of parents, grandparents, and siblings frequently arises.

The therapist must decide which members of the family should be present during which discussions as some children may be too young to comprehend some of the material that must be discussed.

Individual Therapy. Talking to an adult about sex in a closed room can create tension, anxiety, and confusion in child perpetrators. It is counterproductive to recreate a situation that the child could misconstrue as overtly or covertly sexual. Virtually all of these children have lived with or had interactions with adults whose sexual boundaries were unclear and highly inappropriate. Many of these children have been sexually abused. Because of this, the themes and issues around sex and sexuality are often best handled in group therapy. Individual psychotherapy is most useful for issues that are nonsexual and specific to the child, such as the child's relationship to parents/caretakers, school problems, out-of-home placement problems, specific peer or sibling problems, fears, phobias, depression, suicidal or homicidal ideation, etc. Other family members may also benefit from individual therapy.

School Intervention. It is important to make sure that the child's educational needs are being met. Because virtually all child perpetrators have multiple behavioral problems, their education frequently suffers. Many have severe but undiagnosed learning disabilities. If the child is in need of special education services this should be attended to quickly. These children have experienced so many failures that school failures should not be added.

After extensive evaluation and discussion with the child and family, the appropriate school personnel must be alerted if children at school are at risk for being abused. If necessary, a plan can be worked out with the school personnel for very close supervision or special placement until the child is in better control. It is very important to include the parents in all such interventions to impress them with the seriousness of their child's problems and their responsibility to help their child.

Conclusion

Children twelve and under molest other children. Although we do not know how many of these children there are, we do know that the damage to their victims, and their own distress, is substantial. There is no evidence from the therapeutic work to date that the sexually aggressive behavior of these children will abate without significant and prolonged intervention. We must commit resources to the study and treatment of these children. The National Center on Child Abuse and Neglect's allocation of research monies to study the best treatment approaches to these children is a positive step. If it is to be of any help, however, this research must be guided by what makes theoretical sense and what has been empirically corroborated. The research agenda must be informed and well thought out to ensure that the field and the public at large get maximum benefits from the money spent. Without effective treatment, a substantial proportion of these child perpetrators will go on to become adolescent and adult offenders, leaving as their legacy a long trail of victims.

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NEWS

ENDOWMENT FUND CONTINUES TO GROW

—by Theresa Reid

The list of people contributing to APSAC's Endowment Fund is getting longer. Our initial goal is to raise $25,000 to help APSAC achieve financial stability and meet its long-range goals. Among these goals are to launch our own national conference, to produce *The APSAC Handbook on Child Maltreatment,* and to offer scholarships to professionals who can't afford to pay membership dues. You can help by urging your friends, colleagues, and relatives to make APSAC their favorite charity or by making a donation yourself. Potential "Friends of APSAC" will be happy to know that all contributions to APSAC are tax-deductible. The people listed below have generously contributed a total of $4,672 to help APSAC toward its $25,000 goal.

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TOLL-FREE HELP: NATIONWIDE NUMBERS FOR CHILD ABUSE AND NEGLECT SERVICES

800-826-4743	Alliance/Vanished Children Missing Children Hotline
800-227-5242	American Association for Protecting Children
800-448-3000	Boystown National Hotline
800-222-LINK	California Network of Self-Help Centers
800-I-AM-LOST	Child Find Hotline (parents reporting lost children)
800-422-4453	Child Help USA
800-999-9999	Covenant House Hotline (for problem teens and runaways)
800-221-2681	Family Services of America
800-A-WAY-OUT	Hotline for parents considering abducting their children
800-272-0012	Kevin Collins's Foundation for Missing Children
800-872-5437	Missing Children Help Center
800-843-5678	National Center for Missing and Exploited Children
800-222-1464	National Child Safety Council
800-222-2000	National Council on Child Abuse
800-333-SAFE	National Domestic Violence Hotline
800-922-9234	National Information Clearinghouse for Infants with Disabilities and Life-Threatening Conditions
800-999-5599	National Information Center for Children and Youth with Handicaps
800-KIDS-006	National Resource Center on Child Sexual Abuse
800-231-6946	National Runaway Hotline
800-621-4000	National Runaway Switchboard
800-442-HOPE	National Youth Crisis Hotline
800-782-SEEK	Operation Lookout, National Center for Missing Youth (for missing child emergencies and sightings)
800-421-0353	Parents Anonymous (except in California)
800-352-0386	Parents Anonymous (in California)
800-627-3675	Red Flag/Green Flag Resources (sexual abuse prevention materials for children and young women)
800-333-1069	Tough Love (problem teens)
800-236-1222	Tri-County Council on Domestic Violence and Sexual Assault
800-HIT-HOME	Youth Crisis Hotline (child abuse, runaways)

Numbers have been provided by Dan Sexton, News Editor for *The Advisor*.