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Working with Sexually Reactive Children

(A Workshop for Staff and Foster Parents by
Robert S. Wright, RSW
August 9, 2000
Family & Children's Services of Cumberland County)

- Tracy Gray, BA. Psych.
- Lorretta Simmons, PCW

Purposes of Supervision

2 ~~3~~) Stop harm caused by resident to self

1 ~~2~~) Stop harm caused by resident to others

3) Stop harm caused to resident by others (active or passive) - requires competent care

4) Provide structure conducive to healing & learning: a milieu that supports therapy & tx

5) Provide relationships conducive to healing & learning

Self esteem
- organic vs. learned behaviours
- Cycle of esteem

Rationale

This workshop is in some ways a reaction to my observations and beliefs about how Nova Scotians, as individuals and organized agencies, are responding to a very special group of children who are sometimes described as being sexually abusive or labeled as sexual offenders. Over the past 10 years I have watched this group of children be rejected by their parents, shunned by their peers, refused education from the school system, poorly treated by the health care system, ill served by the child welfare system, rejected by foster parents, demonized, institutionalized and incarcerated.

As a result, I have focused some small part of my attention in the last several years to working with extremely difficult children I affectionately call "knuckleheads". Though I use this term to refer to various children with difficult behaviours, I include in this group children with sexually acting out behaviours. As a way to begin, I'd like to offer some definitions and some of my beliefs.

A Few Definitions

Anal Sex: Sexual intercourse that involves the penetration or stimulation of the anus

Child: A person under sixteen years of age unless the context otherwise requires[1]

Masturbation: Erotic stimulation of the genitals commonly resulting in orgasm and achieved by using the hand or other tool created or acquired for this purpose.

Oral Sex: The stimulation of another's genitals using the mouth and or tongue. When the receiver is a female oral sex is sometimes called cunnilingus; when a male, fellatio.

Paraphilia: Intense sexually arousing fantasies, sexual urges, or behaviours generally involving nonhuman objects, the suffering or humiliation of oneself or one's partner, or children or other nonconsenting persons. This word is often used as a catch phrase to describe the range of sexual behaviours considered to be deviant, maladaptive or harmful.

Pornography: Any material that depicts erotic behavior or images (as in pictures or writing) intended to cause sexual excitement.

Pseudo-pornography: Any material, though not produced with the intention of causing sexual excitement, that is used by an individual to arouse sexual excitement. For

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[1] You will notice that this definition is taken directly from the Children and Family Services Act. I like this definition for two reasons: First, it comes from the Act under which our services are provided and second, it is sufficiently flexible to allow us to meet the needs of young people with special needs or circumstances.

example, pages from a catalogue, medical text or women's magazine that are used as a stimulus during sexual fantasizing or masturbation.

Sex Offender: A person who has be convicted of committing a sexual offense against another person. By definition in Canada, any child under the age of 12 cannot be considered to be a sex offender since they are unable to be convicted of a crime. Likewise, even children 12 and over who have engaged in inappropriate sexual activity should not be considered sex offenders unless they have been convicted of a sexual crime.

Sexual Abuse: Any sexual behaviour directed towards another person that is coercive, non-consensual, or takes advantage of a power differential that occurs between the parties due to age or protective/care-giving status of the relationship.

Sexually Reactive: Any sexualized behaviours children exhibit which could be considered coercive, intrusive, inappropriate, excessive, or precocious and is thought to be symptomatic of abnormal sexual development or secondary to sexual abuse victimization.

Credos

I believe that all sexually reactive children should be viewed with compassion

I believe that sexually reactive behaviours should be seen as just another disruptive behaviour

I believe that our difficulty working with children who exhibit sexually reactive behaviours is related in large part to our discomfort about human sexuality issues in general

I believe that children who exhibit sexually reactive behaviours can be helped to return to a more healthy pattern of sexual development

I believe that any competent care-giver or helping professional, with appropriate training and support, can care for, and contribute to the healing of a sexually reactive child

Incidence

During my preparation for this workshop I was unable to find any statistics which described the degree to which children experience problems in their sexual behaviours. I did find some statistics that can be clues to our work however:

• It is estimated that there were nearly 12 000 investigations of child sexual abuse in Ontario in 1993. Sexual abuse was substantiated in 29 percent of these cases and suspected in another 27 percent.

• In British Columbia, more than 500 complaints of sexual abuse were received in March 1992.

• The most extensive study of child sexual abuse in Canada was conducted by the Committee on Sexual Offences Against Children and Youths. Its report indicates that, among adult Canadians, 53 percent of women and 31 percent of men were sexually abused when they were children.[2]

If even a small percentage of sexually abused children experience difficulties as a result of the abuse that they suffer it is not hard to see that the problem can be quite large. Another Health and Welfare Canada Monograph describes the development of sexually reactive acting out in the following way:

> What is secondary abuse?
>
> A teenager or adult may molest a child who then begins to molest other children. There may then be a ripple effect, with the molested children initiating still more children into sexual activity. When this happens in a school or neighbourhood, it may seem hopeless at first glance. But it isn't.
>
> [Snip]
> How does all this work?
>
> Here's a case study to illustrate the point: A teenage sex offender leaves pornographic magazines at strategic locations on a path behind an elementary school. When he spots a potential victim reading a magazine, he comes up and asks him if he would like to know what real sex feels like.
>
> If the potential victim is insecure, lonely, and happy to get some attention, he may say 'yes'. The offender performs oral sex on him. The offender then goes on to molest 2 or 3 other boys in the same manner. He may be able to convince his victims that they are now part of a club, and are sharing in a daring anti-social activity.
>
> At this point peer pressure takes over, and the 'oral sex club' is operating with or without its founder. Deep down all of the members are ashamed of what they're doing, but male bravado forces them to pretend they're enjoying themselves. They

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[2] Taken from a monograph prepared by Health and Welfare Canada on "Child Sexual Abuse". The full text of this document can be found at: http://www.hc-sc.gc.ca/hppb/familyviolence/html/csaeng.html

don't try to back out because of peer pressure. [3]

Defining Normal and Concerning Sexual Development in Children

The following 10 pages are taken from Appendix 1 of "Child Abuse Prevention and Child Protection: A Manual for Child Care Practitioners Working in Regulated Child Care". This manual was prepared by the Nova Scotia Department of Community Services in July of 1998. It is interesting to note that our very own Betsy Prager was the principal author of the manual.

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[3] Taken from a monograph prepared by Health and Welfare Canada on "When Children Act Out Sexually". The full text of this document can be found at: http://www.hc-sc.gc.ca/hppb/familyviolence/html/1actout.htm

Appendix I

Normative Child Sexual Development

BIRTH THROUGH 2.5 YEARS

- shows interest in different postures of boys and girls when urinating
- is curious about physical differences between sexes
- begins to explore genitals

3-4 YEARS

- verbally expresses interest in physical differences
- girls might attempt to urinate standing up
- calling of names related to elimination
- body exploration with other children of both sexes is common
- very conscious of the naval
- under social stress may grasp genitals and may need to urinate
- may demand privacy for self but be very interested in bathroom activity of others
- begins identification with same sex parents

5 YEARS

- less sex play and game of "show"
- mutual body exploration with same sex is common
- reinforcement of gender identity continues
- feelings toward opposite sex becomes more ambivalent
- more modest and less exposing of self

6-7 YEARS

- marked awareness of and interest in differences between sexes in body structure
- may play hospital and take rectal temperatures
- questioning
- mild sex play or exhibitionism in play or in school toilets
- mutual body exploration with same sex

8-12 YEARS: SCHOOL AGE

- by the end of this period, children generally have reasonable knowledge of sexual issues and information - peer school, reading, parents, etc.
- developing an interest in opposite sex - most noticeable in girls
- girls are developing secondary sex characteristics, and many girls have begun to menstruate by age 12
- aware of social "rules" regarding issues of sex

NOTE: It is normal for children to self-stimulate at any of these ages.

When considering childhood sexuality, it is important to keep in mind that young children are naturally curious abou everything. They are certainly no less curious about matters related to sex than any other area of their lives. Children are generally beginning to recognize the differences in sexes by the age of two years. They begin to identify themselves with one sex or the other, though their understanding is most often related to outward appearanc rather than physical differences. The basic understanding of physical difference is usually evident by the age of four Of course, as with any aspect of children's lives, their knowledge is reliant upon experience. For example, if it has been pointed out to a three-year old that a boy has a penis and a girl has a vagina, they may be able to repeat this information, but their understanding of the significance would be very limited.

In the period between 18 months and three years, children are generally freed from their diapers and may more obviously begin to explore their bodies. They are often seen rubbing their genitals. This very early masturbation i very typical and is not at all unusual. How the adults in the environment respond to this activity is certainly what often makes masturbation an issue for the child. There are almost as many views on what adults consider "natural" and "appropriate" as there are adults. Children most likely do not give the act much consideration, as to them, it i simply a matter of pleasurable sensation and exploration. Masturbation can be a "comfort" to the child, just as thumb sucking, rocking or rubbing a soft blanket against the skin are comfort habits. However, considering social perspectives, it is generally not considered appropriate or allowed to continue under normal exploration. The pleasures of masturbation are generally learned incidentally through normal exploration. The child has limited knowledge of the social implications of the act (until informed) nor do they connect a sexual meaning to it as an adu might, for example, they do not connect sexual fantasy to the act. Indeed, what is considered "sexual" or "sexy" varies from culture to culture and thus must surely be learned.

Children, by the age of four, generally recognize that sexual activities are viewed differently than other aspects of their lives. Four year olds may involve themselves in sex talk and sex play. The power of words and play continue to be of interest through to the age of 9 or 10, by which time most children have developed an understanding of th significance of sexual issues. Around the age of 5 - 7, children not only understand that these activities are viewed differently, but also that there are social taboos connected to sex talk and play. Most often by this age they attemp to keep exploration out of the adults view. In childhood, sex play is a common and normal behaviour.

Adults should become concerned when a child seems more interested in sexuality than other aspects of his/her life. This in itself is not a clear indicator of sexual abuse but certainly should be of some concern. More indicators of sexual abuse are found in **Indicators of Possible Abuse or Neglect**, Province of Nova Scotia, as well as in Toni Cavanagh Johnson's **Behaviours Related to Sex and Sexuality in Kindergarten Through Fourth Grade.**

It is important to remember that the range of normal behaviour is extremely wide and is influenced by a multitude factors. A child's knowledge of adult sexual behaviour varies according to parental views, media exposure, siblin and peer group knowledge, and so forth. It is also relevant to note that the names for body parts and bodily functions are often specific to families and thus might not be obvious to outsiders.

Having said that, knowledge varies, as it certainly does, it is also important to remember the developmental limitations of young children's understanding. Young children who are victims of sexual abuse may not recognize their situation as unique. This lack of recognition may be related to the preschoolers egocentric view of how the world works, their lack of information from outside sources, or indeed a combination of both.

Behaviours Related to Sex and Sexuality in Preschool Children

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The following chart attempts to describe behaviours which relate to sex and sexuality of preschool children of normal intelligence. Available literature and empirical data on child sexuality have been studied, and consultation with hundreds of professionals, parents and child care providers has been sought to prepare this chart. It is a first step in defining behaviours related to sex and sexuality which are within the normal range, behaviours which raise concern and behaviours which require immediate assessment and intervention. This chart is not meant for use in the assessment of child sexual abuse. Comments and suggestions are invited by the author.

The behaviours in the first column are those which are in the normal range. This range is wide and not all children will engage in all of the behaviours; some children may engage in none while some may only do one or two. There will be differences due to the child's interest and the amount of exposure the child has had to adult sexuality, nudity, explicit television, videos and pictures. The child's parents' attitudes and values will influence the child's behaviours.

The second column describes behaviours which are seen in some children who are overly concerned about sexuality, children who lack adequate supervision and other children who have been, or are currently being, sexually molested or maltreated.

When a child shows several of these behaviours, a consultation with a professional is advised.

The third column describes behaviours which are often indicative of a child who is experiencing deep confusion in the area of sexuality. This child may or may not have been sexually abused or maltreated. It may be that the level of sex and/or aggression in the environment in which the child has lived overwhelmed the child's ability to integrate it, and the child is acting out the confusion. Consultation with a professional who specializes in child sexuality or child sexual abuse should be sought.

Sex Play is Within Normal Range of Childhood Behaviour

All aspects of normal sex and sexuality for preschool children are related to curiosity and exploration. Preschoolers are trying to find out about the world, how it smells, tastes, works, sounds and feels. Everything related to the genitals, breasts, differences between males and females and procreation are subjects of preschoolers exploration and curiosity. This interest comes and goes.

Areas of Concern

Concern arises when the child focuses on sexuality to a greater extent than 1) other areas of the child's environment or 2) other developmentally matched peers. Interest in sex and sexuality should be in balance with the curiosity and exploration of all other aspects of the child's life. When a child is admonished about certain sexual behaviours yet continues, this raises concern. When a child shows several behaviours which are of concern, professional advice is recommended.

When To Seek Professional Help

When there is secrecy, anger, anxiety, tension, fear, coercion, force or compulsive interest and activity related to sex and sexuality, professional advice should be sought.

Behaviours Related to Sex and Sexuality in Preschool Children

Normal Range	Of Concern	Seek Professional Help
Touches/rubs own genitals when diapers are being changed, when going to sleep, when tense, excited or afraid.	Continues to touch/rub genitals in public after being told many times not to do this.	Touches/rubs self in public or in private to the exclusion of normal childhood activities.
Explores differences between males and females, boys and girls.	Continuous questions about genital differences after all questions have been answered.	Plays male or female roles in an angry, sad or aggressive manner. Hates own/other sex.
Touches the genitals, breasts of familiar adults and children.	Touches the genitals, breasts of adults not in family. Asks to be touched himself/herself.	Sneakily touches adults. Makes other allow touching, demands touching of self.
Takes advantage of opportunity to look at nude persons.	Stares at nude persons even after having seen many persons nude.	Asks people to take off their clothes. Tries to forcibly undress people.
Asks about the genitals, breasts, intercourse, babies.	Keeps asking people even after parent has answered questions at age appropriate level.	Asks strangers after parent has answered. Sexual knowledge too great for age.
Erections	Continuous erections	Painful erections
Likes to be nude. May show others his/her genitals.	Wants to be nude in public after the parent says "no".	Refuses to put on clothes. Secretly shows self in public after many scoldings.
Interested in watching people doing bathroom functions.	Interest in watching bathroom functions does not wane in days/ weeks.	Refuses to leave people alone in bathroom, forces way into bathroom.
Interested in having/birthing a baby.	Boys interest does not wane after several days/weeks of play about babies.	Displays fear or anger about babies, birthing or intercourse.
Uses "dirty" words for bathroom and sexual functions.	Continues to use "dirty" words at home after parent says "no".	Uses "dirty" words in public and at home after many scoldings.
Interested in own feces.	Smears feces on walls or floor more than one time.	Repeatedly plays or smears feces after scolding.
Plays doctor inspecting others' bodies.	Frequently plays doctor after being told "no".	Forces child to play doctor, to take off clothes.
Puts something in the genitals or rectum of self or other due to curiosity or exploration.	Puts something in genitals or rectum of self or other child after being told "no".	Any coercion or force in putting something in genitals or rectum of other child.
Plays house, may simulate all roles of mommy and daddy.	Humping other children with clothes on.	Simulated or real intercourse with another nude child.

Behaviours Related to Sex and Sexuality
in Kindergarten Through Fourth Grade Children

Toni Cavanagh Johnson, Ph.D.
Licensed Clinical Psychologist

The following chart attempts to describe behaviours which relate to sex and sexuality of children of normal intelligence in kindergarten through fourth grade. Available literature and empirical data on child sexuality have bee studied, and consultation with hundreds of mental health professionals, parents and child care providers has been sought to prepare this chart. It is a first step in defining behaviours related to sex and sexuality which are within th normal range, behaviours which raise concern and behaviours which require immediate consultation. This chart is not meant for use in the assessment of child sexual abuse. Comments and suggestions are invited by the author.

The behaviours in the first column are those which are in the normal range. This range is wide and not all children will engage in all of the behaviour; some children may engage in none while some many only do one or two. There will be differences due to the amount of exposure the child has had to adult sexuality, nudity, explicit television, videos, pictures and the child's level of interest. The child's parents' attitudes and values will influence the child's behaviours.

The second column describes behaviours which are seen in some children who are overly concerned about sexuality, children who lack adequate supervision and other children who have been, or are currently being, sexually molested or maltreated.

When a child shows several of these behaviours, a consultation with a professional is advised.

The third column describes behaviours which are often indicative of a child who is experiencing deep confusion in th area of sexuality. This child may or may not have been sexually abused or maltreated. It may be that the level of sex and/or aggression in the environment in which the child has lived overwhelmed the child's ability to integrate it, and the child is acting out the confusion. Consultation with a professional who specializes in child sexuality or child sexual abuse should be sought.

Sex Play

Children in kindergarten through fourth grade are trying to understand their bodies, their abilities, how to make friends and what life is all about. The world is a marvellous place full of things to learn and explore, amongst these are sex and sexuality. Everything related to sex and sexuality, including the genitals, breasts, differences between males and females, love, marriage, intercourse, dirty books and pictures, dancing, hugging, touching, etc., are the objects of great curiosity. Young school-age children are often very active in their exploration of these topics. At times children engage in solitary sexual behaviours, at other times, similar-age children engage in exploratory behaviour together or make up games involving sexual themes in which groups of children engage together. Curiosity about sex is natural and is engaged in with liveliness and good humour. Children engaged in sex play mutually agree to participate and are generally giggly and silly. When one child wants to stop, the other/s stop also. If discovered in sexual behaviours, a child may feel guilty or ashamed, but this passes, if the adult treats it as normal.

Areas of Concern

Concern arises when the child focuses on sex and sexuality to a greater extent than 1) other areas of the child's environment, or 2) his or her peers. Sexual interest should be in balance with the curiosity and exploration of all other aspects of the child's life. Most sexual behaviours related to "looking and touching" go underground or stop as children learn that many adults are unaccepting of much of their overt exploration and curiosity. When a child continues to do sexual things in the view of adults who say "no", this raises concern. Most sexual behaviours by young school-aged children are engaged in with children of similar age; usually within a year or so, younger of

older, of their own age. The wider the age range between children engaged in sexual behaviours, the greater the concern. Sex play usually occurs between friends and playmates. A child who keeps asking unfamiliar children or children who are uninterested to engage in sexual activity, raises concern. Children who appear anxious, tense, confused about sexual issues, or who are continuously involved in sexual activity, or children who do not understand others' admonitions against overt sexual behaviour, also raise concern. If a child shows several behaviours which of concern, professional advice is recommended.

When to Seek Professional Consultation

Generally, there is little concern about peer sexual exploration yet there can be manipulation and coercion between same-aged peers. When assessing peer sexual behaviours which are considered problematic, the every day relationship between the children is the best measure of how the children interact. If a child is regularly aggressive and controlling in interactions with other children, this relationship may be the same when sexual behaviours are occurring. Sexual behaviours between children where one is pressuring the other to engage in the behaviours can be very serious. If other children repeatedly complain about a child's sexual behaviour even after the child has been spoken to, an assessment by a professional is advisable.

When there is anger, anxiety, tension, fear, coercion, manipulation, force or ongoing compulsive interest and activity related to sex and sexuality, professional advice should be sought.

Behaviours Related to Sex and Sexuality
In Young School-Age Children

Normal Range	Of Concern	Seek Professional Help
Asks about the genitals	Shows fear or anxiety about sexual topics	Endless questions about sex. Sexual knowledge too great for age.
Interested in watching/peeking at people doing bathroom functions.	Keeps getting caught watching/peeking at others doing bathroom functions.	Refuses to leave people alone in bathroom.
Uses "dirty" words for bathroom functions, genitals and sex.	Continues to use "dirty" words with adults after parent says "no" and punishes.	Continues use of "dirty" words even after exclusion from school and activities.
Plays doctor, inspecting others' bodies	Frequently plays doctor and gets caught after being told "no".	Forces child to play doctor, to take off clothes.
Boys and girls are interested in having/birthing a baby.	Boy keeps making believe he is having a baby after month/s.	Displays fear or anger about babies or intercourse.
Show others his/her genitals.	Wants to be nude in public after the parent says "no" and punishes child.	Refuses to put on clothes. Exposes self in public after many scoldings.
Interest in urination and defecation.	Plays with feces. Purposely urinates on floor.	Repeatedly plays or smears feces. Urinates on furniture on purpose.
Touches/rubs own genitals when going to sleep, when tense, excited or afraid.	Continues to touch/rub genitals in public after being told "no". Masturbates on furniture or with objects.	Touches/rubs self in public or in private to the exclusion of normal childhood activities. Masturbates on people.
Plays house, may simulate all roles of mommy and daddy.	Humping other children with clothes on. Imitates sexual behaviour with doll/stuffed toy.	Humping naked. Intercourse with another child. Forcing sex on other child.
Thinks other sex children are "gross" or have "cooties". Chases them.	Uses "dirty" language when other children *really* complain.	Uses bad language against other child's family. Hurts other sex children.
Talks about sex with friends. Talks about having a girl/boy friend.	Sex talk gets child in trouble. Gets upset with public displays of affection.	Talks about sex and sexual acts alot. Repeatedly in trouble in regard to sexual behaviour.
Wants privacy when in bathroom or changing clothes.	Becomes very upset when seen changing clothes.	Aggressive or tearful in demand for privacy.
Likes to hear and tell "dirty" jokes.	Keeps getting caught telling "dirty" jokes. Makes sexual sounds, e.g. moans.	Still tells "dirty" jokes even after exclusion from school and activities.
Looks at nude pictures.	Continuous fascination with nude pictures.	Wants to masturbate to nude pictures or display them.
Plays games with same-aged children related to sex and sexuality.	Wants to play games with much younger children related to sex and sexuality.	Forces others to play games related to sex and sexuality. Group forces child/ren to play.

Normal Range	Of Concern	Seek Professional Help
Draws genitals on human figures.	Draws genitals on one figure and not another. Genitals in disproportionate size to body.	Genitals stand out as most prominent feature. Drawings of intercourse, group sex.
Explores differences between males and females, boys and girls.	Confused about male/female differences after all questions have been answered.	Plays male or female roles in a sad, angry or aggressive manner. Hates own/other sex.
Takes advantage of opportunity to look at nude child or adult.	Stares/sneaks to stare at nude persons even after having seen many persons nude.	Asks people to take off their clothes. Tries to forcibly undress people.
Pretends to be opposite sex.	Wants to be opposite sex.	Hates being own sex. Hates own genitals.
Wants to compare genitals with peer-aged friends.	Wants to compare genitals with much older or much younger children or adults.	Demands to see the genitals, breasts, buttocks or children or adults.
Wants to touch genitals, breasts, buttocks of other same-age child or have child touch him/her.	Continuously wants to touch genitals, breasts, buttocks or other child/ren. Tries to engage in oral, anal, vaginal sex.	Manipulates or forces other child to allow touching of genitals, breasts, buttocks. Forced or mutual oral, anal or vaginal sex.
Kissing familiar adults and children. Allowing kissing by familiar adults and children.	French kissing. Talks in sexualized manner with others. Fearful of hugs and kisses by adults. Gets upset with public displays of affection.	Overly familiar with strangers. Talks in a sexualized manner with unknown adults.
Looks at the genitals, buttocks, breasts of adults.	Touches/stares at the genitals, breasts, buttocks or adults. Asks adult to touch him/her on genitals.	Sneakily or forcibly touches genitals, breasts, buttocks of adults. Tries to manipulate adult into touching him/her.
Erections	Continuous erections	Painful erections
Puts something in own genitals/rectum	Puts something in own genitals/rectum when it feels uncomfortable. Puts something in the genitals/rectum of other child.	Any coercion or force in putting something in genitals/rectum of other child. Anal, vaginal intercourse. Causing harm to own genitals/rectum.
Interest in breeding behaviour of animals.	Touching genitals of animals.	Sexual behaviours with animals.

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How Does Being Sexually Abused Cause a Child to be Sexually Reactive?

There are two models for understanding the mechanism by which children become sexually reactive secondary to being abused. The first is by far the most accepted by persons within the helping community. The second is a more medically modeled approach which I have been considering for sometime now. Since it is not widely referred to I'll mention it only briefly here. For purposes of discussion in this workshop I'll refer to the first model as the re-enactment-reorganization model, and the second as the precocious sexualization model.

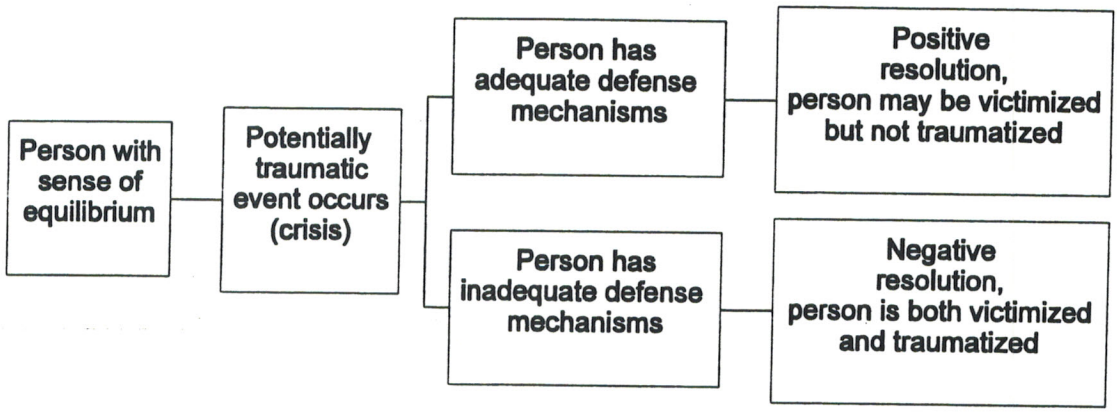
Re-enactment-reorganization model

A basic understanding of the psychological model for understanding trauma is helpful in understanding re-enactment-reorganization. I offer the following text and diagram from my workshop on trauma and an excerpt from Darlene Kordich Hall's work "Assessing Child Trauma" to aid in my description of this process:

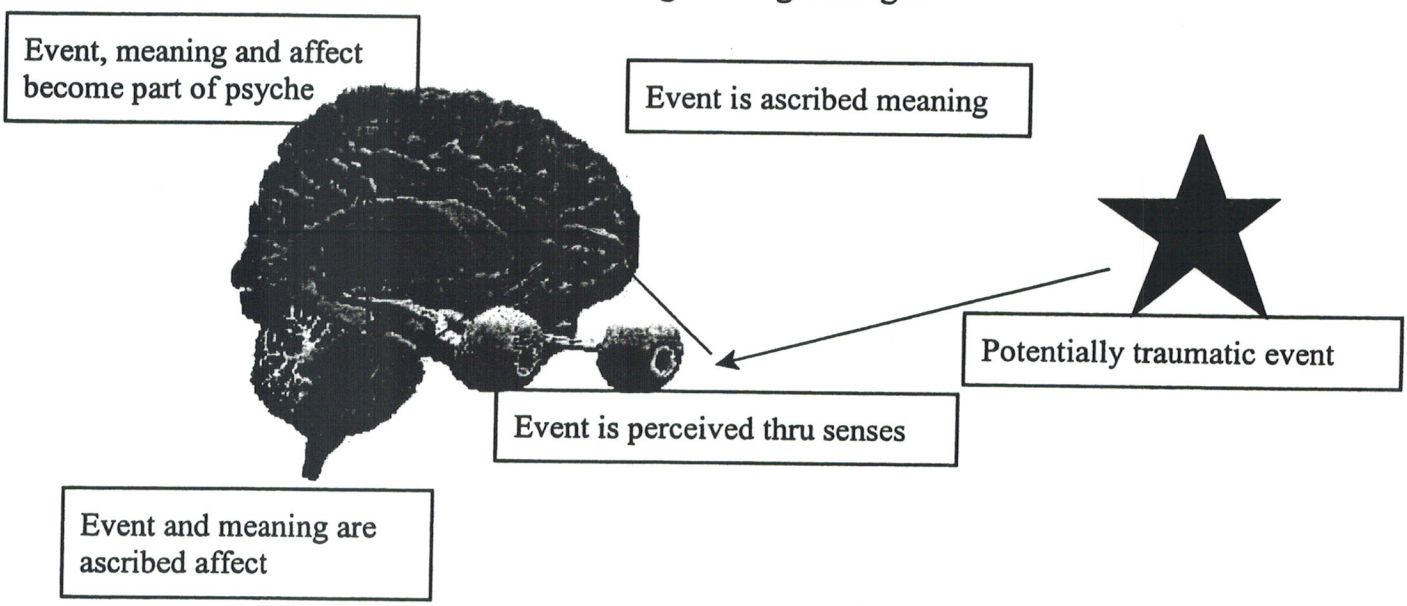
The Psychological Model [of understanding trauma]

To understand the psychological model we must consider 2 concepts; defense mechanisms and the crisis construct. Defense mechanisms (or coping styles) are automatic psychological processes that protect the individual against anxiety and from the awareness of internal or external dangers or stressors (DSM-IV pg. 751). These defense mechanisms are organized into 7 categories ranging from highly adaptive methods to extremely maladaptive methods. These defense mechanisms control how we perceive and respond to events. I often describe this complex process with the following simple diagrams.

The Crisis Construct



The Thinking/Feeling Dialogue



Post-traumatic play (intrusive recollections)

Post-traumatic play is frequently the manner in which young children demonstrate their recurrent and distressing recollection of negative events. (In contrast to young children, older children may process this area more like an adult and describe themselves as having disturbing thoughts or images of the traumatic events.)

Post-traumatic play is often most problematic for both caretakers and clinicians to identify. Caretakers have a difficult time understanding how this type of play is different from a child's "normal" play. We have had some success in describing this type of play in the following manner. Post-traumatic play is the child's attempt to recreate the negative experience in a controlled way so that he/she can try to understand and master the experience. Normally the child won't make a carbon copy of his experience, but instead chooses to use symbols to represent aspects of his/her experience. However, some children will actually enact elaborate, and virtual "re-creations" of their experience within the limits of their developmental understanding and physical abilities.

In addition, we speak to caretakers about specific behaviours which they may have observed and highlight for them the areas of difference between post-traumatic play and the child's usual play:

(1) In this play, themes are often persistently catastrophic, violent, bizarre or highly unusual, and/or sexualized.

(2) This play often does not have a happy ending or resolution which allows the child to be the "master" of it (as would be the case in normal play).

(3) This type of play has a "driven" quality which is unlike the "light-hearted" play normally seen in children. The child doesn't "enjoy" this play and in fact the child may show a tremendous sense of seriousness and absorption in this activity. Post-traumatic play usually excludes others. In many cases the child simply appears to be in his/her "own world" and may even be unaware that others are present. In some children post-traumatic play is accompanied by the child's entry into a dissociative state.

(4) The emotions shown are very intense and may re-create those the child experienced during the traumatizing event(s). These emotions are often so vivid that observers speak of being emotionally affected by the play and may describe feeling frightened or victimized themselves if the child includes them in their play. We often tell trainees that if they feel like they have been victimized and are experiencing a sense of exhaustion after this play, then they were probably witness to post-traumatic play. Because of the intensity and disturbing themes of this play, when other children who were not part of the original trauma are enlisted in this play, they may experience "vicarious victimization" and sometimes even become symptomatic for short periods of time. They may become anxious or fearful, have nightmares, show increased aggression, and participate in secrecy and/or trickery as well.

(5) The play normally has elements of "secrecy" in it as the child may only engage in this activity when he is alone and not around others. Caretakers often report that they only know the child is engaging in this type of play because they can hear the child in another room screaming and speaking harshly to his toys and knocking them about. Other caretakers tell us that they never see this play but find evidence of it. For example, in one case the parent continually found the child's dolls with all of their heads and extremities removed and having had red marks coloured on them as if to signify blood.

(6) This play is highly repetitive with the same themes reoccurring usually without resolution. In some cases parents report children obsessed with this play, preferring to engage in it above all else. When changes are seen it is usually an addition of more specificity and elaboration on the same basic themes, as if the child were now remembering more details.

The assessor will often need to encourage caretakers to listen more carefully to the **content** of their child's play. They should be asked to document the themes of any repetitive play and to try to tune into the child's "alone" play. As well, they should be asked to note any unusual play which makes the caretaker feel uncomfortable, confused, or which seems out of the range of most children's play or is different than their child's normal play activity. Finally, caretakers (and professionals) need to be especially attuned to their own emotional reactions in any play that the child initiates with them, i.e. are they feeling:

(1) uncomfortable?
(2) physically intruded upon?
(3) sexually uncomfortable or invaded?
(4) angry?
(5) abused or exploited?
(6) tricked or lied to?
(7) a little scared or worried about what the child might do (to them) next?

These feelings are often reported by caretakers and professionals who have played with children engaged in post-traumatic play. They are often the first indication one has that this play is not developmentally appropriate and should be "tracked" further and assessed.

Intense emotional distress at similar events

Another reaction frequently seen in traumatized children is the exaggerated and frequently "unusual" responses children have when "triggered" by something in the environment which reminds them of some element(s) of the negative events. Children under these circumstances may become terrified, profoundly agitated and hyperactive, and/or immobilized in response to these stimuli. Caretakers often describe scenes in which "out-of-the-blue" the child screams, clings to them, starts crying, shakes like a leaf, vomits and/or has diarrhea. In extreme cases children may even become become feverish and physically ill. Parents have talked about responses such as these going on for several minutes and lasting upwards to an hour or even more. Children may always have the same reaction to just one stimulus, or they may have a range of responses to a variety of "triggers." These responses may seemingly come and go or change in characteristics (both "trigger" and response) over a lengthy period of time. Some adult trauma survivors speak about life-long terror responses to certain types of objects or events, while others describe rather long "dormant" periods and then the sudden re-emergence of severe reactions to groups of related stimuli.

When children show strong distress responses to certain stimuli they are probably demonstrating emotions felt during the original trauma. At first, caretakers often are unable to identify the stimulus and only after repeated occurrences are they sometimes able to sort out possible "triggers" which cause such a reaction. Caretakers have described these behaviours to us as a response to many types of stimuli. Adverse responses to the dark, water, toileting, certain types of people, and enclosure in small spaces are among the most common "triggers" we have encountered. Other more unusual stimuli have been snakes, lit cigarettes, mops, wooden chairs, pictures in magazines of children lying down on a bed, people counting, certain colors and/or smells, and farm landscapes to mention just a few. Virtually anything can be a trigger if the child associates it with the original trauma.

Caretakers need to be reassured that the practitioner will not think them foolish (or crazy) if they describe to the assessor their child's seemingly incomprehensible reactions, nor will the professional censure their educated guesses as to what might be causing these reactions. Parents and other caretakers should be instructed to record any of the child's unusual distress responses. They should note what occurred just before, what happened during the child's distress response, and what was said or done after the response was over. All of this information will be essential to the assessment and later treatment of the traumatized child.

Briefly then, this model suggests that childhood sexual trauma which results in psychological trauma may be re-enacted in play and other behaviour as a child attempts to analyze the traumatic event in an effort to understand it. This model suggests that this process occurs on a subconscious or sub-intentional level such that the sexually reactive child is not necessarily able to describe why they act out.

Precocious Sexualization Model

This model is much more medical in its orientation and suggests simply that the premature and traumatic stimulation of a child's sexual organs may trigger a series of biological and psychological processes that result in the premature sexualization of a child. I offer the following theory:

> Traumatic sexually abusive activities create physiological distress and stimulation for the child
>
> This physiological stimulation (which is sometimes directly applied to child's sexual organs) creates a disequilibrium within the child's biological system, including premature sexual stimulation of sex organs and brain centers related to sexuality
>
> The hormonal system responds to reestablish homeostasis through the hypothalamus-pituitary-adrenal axis creating a dysregulation in this system
>
> The dysregulation of the hypothalamus-pituitary-adrenal axis results in premature development of sexual organs and brain centers involved in the development of sexual drives
>
> The response to this precocious development of physiological and psychological centers is an increased level of response to further sexual stimuli in the environment, excessive pursuit of sexual stimuli, and increased physiological and psychological response to this stimuli

Though this process as described above cannot be found articulated so clearly in the literature, there is information in the literature that is suggestive:

> Precocious puberty caused by genetic predisposition, brain tumors or other disorders of the adrenal system, has been found to be accompanied by premature interest in sex.
>
> Environmental factors such as stressful family environments has been seen as a cause for precocious puberty in girls

Dysregulation of the hypothalmic-pituitary-adrenal axis caused by childhood abuse has been related to adult onset of depression in both men and women

Dysregulation of the hypothalmic-pituitary-adrenal axis in sexually abused girls has been documented

Abnormal levels of certain hormones (such as cortisol) have been related to increased levels of violence and aggression in young males

In all likelihood these models are not discreet but work together to produce the range of behaviours we understand as sexually reactive behaviours in children. The models for understanding do help us though to target our approaches to helping the children in our care.

Do children who act out sexually harm themselves?

Yes. Children who act out sexually, and are not stopped, hurt not only other children, but may also harm themselves. Because they relate to other children in a sexual way, they may deprive themselves of a chance to have real friendships. When children have a guilty secret [or an excessively sexual manner of relating to others], it is impossible for them to be open with others [or to develop appropriate relationships].

Unless someone intervenes to break the secrecy [or the sexually reactive behaviour], the child who molests other children runs the risk of becoming sexually addicted [or compulsive]. A sense of power over others, plus sexual excitement, can be extremely rewarding, particularly since it compensates for poor self-esteem. The longer the sexual activities continue, the more addictive they become. If they continue into adolescence they are difficult to stop.

How can you help the child who molests other children?

You can help by intervening early when you first suspect abuse. Since sexual abuse of any kind thrives on secrecy, breaking secrecy is the first step towards helping everyone involved. Children who molest must be interviewed by social services or police for two reasons: to help them admit to what they have done, and to provide clues as to why they are doing it. Once they admit to molesting, they are much less likely to continue. As long as they deny what they are doing, and deny their own probable victimization, they are much more likely to continue molesting.

Children who molest should always be viewed with compassion.

Once the secrecy is broken there are many ways in which parents, teachers and other responsible adults can help:

As a parent [or caregiver of a sexually reactive child], you can help in several different ways:

1. You must believe the victim's story. There is always a temptation to believe that your own child [or the child you have come to love] can do no wrong.

2. You can make your own child [or the child you are caring for] accountable by asking him/ her to say exactly what has happened.

3. You should watch your own children's play, and monitor their TV watching. If you own a VCR, you should be aware of the videotapes that come into your home.

4. If you have been lax about respecting family privacy needs, you may need to set some new rules about such things as nudity, closed doors and sexual activity. [If you are caring for a sexually reactive child for the first time, you may want to talk to the child's social worker or therapist about your family's rules and boundaries in this area. It may be necessary to adjust to meet the needs of the sexually reactive child.]

5. You must maintain affection and support for your child. The sexually acting-out child already has low self-esteem, and is going through a life crisis. The child needs plenty of love, providing it isn't sexualized.

6. If the social workers or police recommend counselling for the child, it is important for you to comply. Parents sometimes believe that if they simply scold the child or withdraw privileges, the problem will be solved. They often believe that a problem will go away of its own accord if it isn't discussed. Nothing could be farther from the truth.

7. You can work with your child's counsellor as much as possible to help your child [or the child you care for] change his/her behaviour. This is even more important than thinking about why your child has been molesting.

8. [You can work at expanding your comfort level with talking about human sexuality. Your embarrassment and shame when talking about sex only heightens the child's discomfort and sends the

message that you aren't able to handle them]

9. [You can work at avoiding language that is inaccurate or carries with it negative judgements about things that are widely considered to be "normed" sexual expressions. Try using "gay/lesbian" instead of homosexual, "anal sex" instead of Sodomy, paraphilia instead of pervert or perversion, sexually reactive instead of sex offender, masturbation instead of any of those nasty terms.]

10. [You can talk to other adults who have values similar to yours to discover ways to transmit your values to the child in your care without appearing judgmental or censorious.]

Breaking secrecy is the first step towards helping everyone involved. [Part of breaking secrecy is breaking the attitude that makes talking about all sexual activity taboo. The sexually reactive child must hear you speak openly and frankly about sexuality, particularly when it comes to describing the child's sexually inappropriate behaviours. Referring to the child's "problem" or "habit" rather than their "excessive masturbation" or "explicit and inappropriate sexual language in the presence of others" only heightens the child's belief that you are powerless to help them.]

As a teacher, you can help by observing children's behaviour both in the classroom and on the playground. If there is sexual language, genital-grabbing, or other anti-social behaviour, you must confront and stop it. Your discomfort may tempt you to either ignore it or react too harshly. Treat it matter-of-factly like hitting, cheating, swearing or any other socially unacceptable behaviour. [This is a critical point, we must treat sexually reactive behaviour like any other inappropriate behaviour.]

Schools can help by using sexual abuse prevention programs. School programs have already encouraged thousands of children to disclose incidents of sexual abuse. Teachers presenting these programs should point out that it isn't just strangers in cars who molest children. It may be family members and it may even be other children. [It is also important for schools to recognize that sexually inappropriate behaviour is being exhibited by other children. It is not just the child who is already labelled sexually reactive who is grabbing the crotch or chest of or making lewd gestures towards other students. It is helpful if schools become more vigilant in attending to all sexually inappropriate behaviour exhibited by all children.]

Police can help by warning children of the consequences of their activities if they are carried into adolescence or adulthood. [This should be done carefully. We do not want to convey the message to sexually reactive children that they are destined to grow up to be sexual abusers.]

Social workers can help parents identify patterns of family behaviour that contribute to the molesting; for example, having pornographic material readily available to the children at home. They can also help by referring children to counsellors who specialize in sexual abuse cases.

Sexual abuse counsellors can help children understand the causes of their molesting behaviour, and learn how to control it.

If you're the parent of a child who has molested another child, you should get professional help either from your child's sexual abuse counsellor, or from a counsellor of your own.[4]

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[4] Taken from a monograph prepared by Health and Welfare Canada on "When Children Act Out Sexually". The full text of this document can be found at: http://www.hc-sc.gc.ca/hppb/familyviolence/html/1actout.htm