TEXAS
Department of Family
and Protective Services

Child Sexual Aggression Resource Guide

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INTRODUCTION & PURPOSE

Children who exhibit sexually aggressive behavior need special attention, care, and supervision. These children have complex needs which may be challenging to manage. This guide provides a practical approach to identifying the differences between appropriate developmental behavior, problematic sexual behavior, and sexually aggressive behavior.

One of the underlying principles of this guide is the importance of caseworkers and caregivers working towards a healthy outcome for a child exhibiting either sexual behavior problems or sexually aggressive behaviors, while also protecting other children they come into contact with while in the foster care system and the community.

If sexually aggressive behavior is identified, it must be indicated in the child's case record by the Conservatorship (CVS) Program Administrator and reflected in the child's placement summary form and application for placement.

Note: In Community Based Care (CBC) catchment areas, caseworkers must follow the placement process outlined in the relevant CBC Operations Manual. The placement summary form is not used in CBC areas, as the Single Source Continuum Contractor (SSCC) has its own forms used for communication with placements.

This guide is ***not*** to be used to determine interventions and supports for children and youth who have been the victim of sexual abuse. While there might be some situations where a child who is the victim of sexual abuse also displays sexually aggressive behavior, do not assume there is a relationship between the two situations. The child's behavior should be assessed to determine if it indicates that sexual aggression is a current behavior regardless of any history the child may have as a victim of sexual abuse. Also, it is important to acknowledge the difference between a history of sexual aggression and current sexually aggressive behavior. Once intervention occurs and the child demonstrates changed behavior, the child will always be identified as having a sexual behavior problem but may no longer be identified as sexually aggressive.

This guide focuses on how to:

- Identify current behavior.
- Document and communicate that behavior with caregivers and others.
- Differentiate between appropriate, problematic, and aggressive behaviors.

Finally, this guide provides Program Administrators with the information needed to identify a child with sexually aggressive behavior in IMPACT.

IDENTIFIYING & ASSESSING SEXUALLY AGGRESSIVE BEHAVIOR

A CVS Program Administrator (PA) is the designated individual responsible for determining if a child's behavior meets the definition of sexually aggressive. When circumstances require the PA to determine if a child demonstrates sexually aggressive behaviors, the CVS PA must follow the protocols in this resource guide. Caseworkers must obtain as much information as possible to help inform this decision. *Please note in areas where Community Based Care has been implemented, the SSCC must identify the position that will be responsible for making the designation within the catchment area as a part of the protocols developed during the start-up phase. The SSCC will be contractually responsible for ensuring the appropriate implementation of all Child Sexual Aggression Protocols outlined in this Resource Manual.*

If a caseworker suspects that a child has sexually aggressive behavior, the caseworker MUST notify the CVS PA immediately. The notification can be done by email with a copy to the Supervisor and Program Director.

The PA should gather the following information to determine if the child's behavior meets the definition of sexually aggressive behavior:

- Age of all children at time of incident(s) as well as any developmental delays present.
- The date and location of where the incident(s) occurred.
- A description of the incident.
- Any documented history of sexually aggressive behavior, as defined in this document.
- Any Child Advocacy Center (CAC) forensic interviews of the child in question or of any alleged child victims.

DEFINITIONS & TERMS

CHILD

Child means a child or youth in DFPS conservatorship.

SEXUAL BEHAVIOR PROBLEM

A sexual behavior problem is when a child exhibits sexual activities or actions that are outside the range of those which are developmentally appropriate. This behavior may indicate that the child should be referred for services, but does not require the CVS PA to indicate sexually aggressive behavior on the sexual aggression page in the IMPACT system. The next section provides information on normal sexual development, sexual behavior problems, and sexually aggressive behavior.

Mark the ***sexual behavior problem*** characteristic on the person detail page if a child meets the criteria outlined in the sexual behavior chart. Once the CPS Caseworker identifies this as a characteristic, there will be no end-date, as a child will always have a history of this behavior.

SEXUALLY AGGRESSIVE BEHAVIOR:

While this guide primarily addresses situations in which a child has been sexually aggressive with another child, there may be times when an adult may be a victim of sexual aggression by a child. Sexually aggressive behavior occurs when a child takes advantage of another person who is less powerful through seduction, coercion, and/or force.

- Less powerful: Differences in developmental level, physical stature, cognitive ability, and/or social skills.
- Seduction: The use of charm, manipulation, promises, gifts, and flattery to induce a person to engage in sexual behavior.
- Coercion: The exploitation of authority or the use of bribes, threats, threats of force, and/or intimidation to gain cooperation or compliance.
- Force: Threat or use of physical or emotional harm towards a person, and/or someone and/or something a person cares about.

Note: Human trafficking recruitment does not in and of itself meet the guidelines for the CSA indicator, unless there are other behaviors that meet the CSA definition in the Sexual Behaviors Chart. However, any history of recruitment must be addressed, documented for future placements, and appropriately treated. If there is confusion over how to classify a child's behaviors, staff the child's history with your chain-of-command, including the Conservatorship Program Administrator for consideration for designation of child sexual aggression.

The CVS PA documents ***child sexual aggression*** on the sexual aggression page in IMPACT if he or she determines that a child has this characteristic.

Sexual orientation or gender identity are not indicators of sexual behavior problems or sexually aggressive behavior.

KINSHIP HOME

A placement where a child resides with a relative or fictive kinship caregiver. The caregiver has undergone a background check and a home assessment but is not a verified foster home.

KINSHIP FOSTER HOME

A placement where a child resides with a relative or fictive kinship caregiver and the caregiver is a verified foster home.

CONTRACTED PLACEMENT

A placement that is under a contract with DFPS through Residential Child Care Contracts or with an SSCC as a part of Community Based Care.

SEXUAL BEHAVIOR CHART

Age	Normal Sexual Development	Sexual Behavior Problem	Sexually Aggressive Behavior
Less than 4 (preschool)	• Touches genitals in public and private. • Frequent erections. • Explores one's body. • Enjoys being naked. • Tries to touch private parts of others and see others naked.	• Curiosity about sexual behavior becomes an obsessive preoccupation. • Exploration becomes reenactment of specific adult activity. • Behavior involves injury to self or others.	• Exploration becomes reenactment of specific adult activity and involves other children. • Behavior involves injury to self or others.
4-6 (young children)	• Develops sense of being male and female. • Explores own body more purposefully. • Knows touching feels good but not necessarily that it should be done in private. • Has lots of questions and curiosity. • “Plays doctor” and shows private parts to others. • Talks about bodily functions. • Touches or tries to view peer/sibling body/genitals.	• Discusses specific sexual acts or explicit sexual language	• Sexual touching that involves coercion, threats, secrecy, violence, and aggression. • Anal sex with another child. • Vaginal sex with another child. • Oral sex with another child. • Masturbating another child. • Forcing another child to watch masturbation.

Age	Normal Sexual Development	Sexual Behavior Problem	Sexually Aggressive Behavior
7-12 (school aged)	• Purposefully touches own genitals • Plays games (e.g., truth or dare) about/explores sexual behavior with other children • Looks at pictures of naked people • Wants more privacy • Begins sexual attraction to peers • Questions about relationships, sexual behavior and menstruation/pregnancy	• Describes aggressive/violent sexual acts. • Sexual penetration. • Oral sex. • Simulated intercourse. • Masturbating in public • Chronic preoccupation with sex/pornography (including online).	• Sexual touching that involves coercion, threats, secrecy, violence, and aggression. • Anal sex with another child. • Vaginal sex with another child. • Oral sex with another child. • Masturbating another child. • Forcing another child to watch masturbation.
13-17 (teens)	• Has markedly more sexual interest in others. • Sexual activity/experimentation with children of the same age. • Expresses sexual orientation and sexual identity. • Sexual interaction through technology and social media. • Masturbation in private.	• Sexual contact with animals. • Sexual interest directed towards much younger children. • Chronic preoccupation with sex/pornography (including online). • Masturbating in public.	• Sexual touching that involves coercion, threats, secrecy, violence, and aggression • Anal sex with another child. • Vaginal sex with another child. • Oral sex with another child. • Masturbating another child. • Forcing another child to watch masturbation. • Forcing another child to watch pornography.

DYNAMICS OF A CHILD WITH SEXUAL AGGRESSION

There are many possible reasons why children exhibit sexually aggressive behaviors. In general, children's sexual behavior problems are rarely about sexual pleasure. In fact, these behaviors are much more likely to be related to the factors below:

- Exposure to traumatic experiences: abuse, natural disasters, accidents, and/or violence, including domestic violence;
- Excessive exposure to adult sexual activity and/or nudity in the home (including media exposure through television or the Internet);
- Inadequate or inappropriate rules about modesty or privacy in the home;
- Inadequate or inappropriate supervision in the home, often as a result of parental factors such as depression, substance abuse, or frequent absences.

While the following behaviors do not necessarily indicate sexually aggressive behavior, they are examples of behavioral and social difficulties that children with sexually aggressive behavior may also exhibit:

- Impulsiveness and a tendency to act before thinking.
- Difficulty following rules and listening to authority figures at home, in school, and in the community.
- Problems making friends their own age and a tendency to play with much younger children.
- A limited ability to self soothe (calm themselves down), so they may touch their own genitals (masturbate) as a way to release stress.[1]

[1] Understanding and Coping with Sexual Behavior Problems in Children. (2015). Retrieved June 16, 2016, from http://nctsn.org/nctsn_assets/pdfs/caring/sexualbehaviorproblems.pdf

PROTOCOLS WHEN A CHILD HAS SEXUALLY AGGRESSIVE BEHAVIORS

CHILD WITH SEXUALLY AGGRESSIVE BEHAVIOR COMES INTO CONSERVATORSHIP

REMOVAL CASEWORKER	REMOVAL SUPERVISOR	CVS PROGRAM ADMINISTRATOR
The Removal Worker staffs any sexually aggressive behaviors that have been identified through the course of the investigation or open FBSS case and removal with the Removal Supervisor.	If the Removal Supervisor identifies sexually aggressive behaviors, the Removal Supervisor staffs the case with the CVS PA as soon as possible but no later than 24 hours after being made aware of the behaviors.	The CVS PA reviews the investigation and/or information from current or past INV, FBSS, or CVS cases and the Child Sexual Aggression Guidelines to determine if the child's behavior meets the definition of sexually aggressive behavior. If the child does not meet the definition, a staffing is entered into the contact narrative.
		If the child does meet the definition, the CVS PA documents the rationale for the indicator in IMPACT for both the child with sexual aggression and the victim child. In the SUB stage for the child with sexual aggression document on the sexual aggression page in IMPACT: • The victim's name and PID. • If the name of the victim is unknown, identify the relationship and any additional identifying information. • The IMPACT case number. • A description of the behavior. • The date of the incident. • If the victim child is in the conservatorship of DFPS, In the SUB stage for the

REMOVAL CASEWORKER	REMOVAL SUPERVISOR	CVS PROGRAM ADMINISTRATOR
		victim child document in the special handling box: • The name and PID of the child who was sexually aggressive • Description of the incident • Relationship to the victim. • The date of the incident.
		Within 24 hours of the staffing with the Removal Worker, the CVS PA notifies the following people of the decision, including the rationale for the decision made: • Removal worker. • Removal Supervisor. • CVS PD. • CVS Supervisor. • CVS Caseworker. • SSCC staff member assigned (if applicable).
If the child has not been placed, the removal caseworker updates the following documents with the information about sexual aggression before submission to Centralized Placement Unit (CPU)/Residential Treatment Placement Coordinator (RTPC): • Abbreviated version of the application for placement (form 2087EX).		

REMOVAL CASEWORKER	REMOVAL SUPERVISOR	CVS PROGRAM ADMINISTRATOR
• Placement summary form (Form 2279) * in CBC catchment areas, follow the placement process in the relevant CBC Operations Manual.		
If the child has already been placed, and the placement is not aware of the child's behavior, the removal worker IMMEDIATELY notifies the placement about the child's behavior and documents the notification in IMPACT.		
	Before case transfer, the removal supervisor ensures the following information is in IMPACT: • The staffing contact is entered by the removal worker.	

RCCI INVESTIGATION OF A CHILD PLACED IN A LICENSED PLACEMENT

CPS Protocols	RCCI Protocols
Caseworker (CW) is notified of the RCCI investigation.	Residential Childcare Investigations (RCCI) notifies CW of the RCCI intake. If RCCI has instituted a safety plan, the requirements of the safety plan are provided to the CPS caseworker.
CW reviews RCCI intake in IMPACT (RCCI Investigator notifies the CW via e-mail providing the IMPACT case ID number so that CW can view the case in IMPACT).	
CW notifies the supervisor of investigation immediately and safety factors in the placement, including any safety plans established by RCCI, are discussed in a staffing. Document the staffing in a contact narrative.	
	RCCI notifies CW when initial face-to-face (FTF) interview with child is completed.
CW notifies parents and parties according to CPS Policy 6151.3.	
CW visits the alleged aggressor child to assess safety, including any requirements established in a safety plan, and determine if additional actions are needed to ensure child safety and if supportive services are necessary and then arranges services immediately. (*CW does not interview the child about the allegations or discuss the investigation with the caregiver but they can and must assess safety and determine what supports the child needs*). CW of victim visits the child to assess safety, including any requirements established in a safety plan, and determine if additional actions are needed to ensure child safety and if supportive services are necessary and then arranges services immediately.	RCCI notifies the operation of the allegations any time an investigation is being conducted and requests a safety plan if needed. The only exception to notifying operation of an investigation may be if the allegations are against the director/administrator or if there is a reason notification of the investigation may compromise the investigation. The caregiver should be aware of the allegations unless there are aforementioned exceptions. At any time RCCI requires a safety plan, the contents of the plan must be shared with the CPS CW.

CPS Protocols	RCCI Protocols
CWs of alleged aggressor and victim maintain contact with the RCCI investigator and the child during INV to continue to assess child safety. CW must staff and take appropriate actions at any time to ensure the safety of the child sexual aggressor and/or the child victim.	
CW works with RCCI to refer the victim child to the Children's Advocacy Center (CAC) for a forensic interview, if necessary.	RCCI works with the CPS CW to refer the victim child to CAC for a forensic interview, if necessary.
	RCCI keeps CPS informed throughout the investigation. RCCI notifies CWs of aggressor and victim conclusion and disposition of the investigation.
CWs of alleged aggressor and victim notify supervisor and PD about investigation findings.	
CW reviews the investigation and places a copy of the completed investigation in the child's case file (both the victim and aggressor child's file).	RCCI provides the CW's of the aggressor and victim with a copy of the investigation report at the end of an investigation.
If the findings include the discovery of sexually aggressive behavior or if the CW believes that the behaviors meet the definition of sexual aggression, the CW **IMMEDIATELY** notifies the CVS PA and copies the CVS supervisor and CVS PD. The CW includes the child's name, the CLASS case ID (from the Investigation Report obtained from RCCI); the child's PID, and the child's DOB. If the PA determines that it does not meet the definition of CSA, the PA documents the decision in a contact narrative as a case staffing.	If the findings include the discovery of sexually aggressive behavior, the RCCI Investigator **IMMEDIATELY** notifies the RCCI PA, who: • Reviews the investigation and the High Risk Behavior Guidelines to determine if the incident meets the definition of sexually aggressive behavior.
The CPS PA notifies the RCCI PA of the case and findings unless already contacted by the RCCI PA.	The RCCI PA notifies the CVS PA of the case and findings and includes the child's name,

CPS Protocols	RCCI Protocols
	the CLASS case ID; the child's PID, and the child's DOB.
The CVS PA: • Reviews the investigation and the Child Sexual Aggression Resource Guide to determine if the child's behavior meets the definition of sexually aggressive behavior. • Confers with the RCCI PA on RCCI investigations to ensure that the two agencies agree that the definition was met.	The RCCI PA confers with the CVS PA on RCCI investigations to ensure that the two programs agree that the definition was met. If agreed, the RCCI PA marks the indicator in CLASS.
If the RCCI PA and the CVS PA do not agree that the behavior meets the definition of sexually aggressive behavior, the CVS PA must elevate the decision to the RD to review with the Child Care Investigations Division Administrator. If no agreement can be made at the regional level, the CVS PA elevates the decision to the RCCI State Office Director and CPS Director of Field.	If the RCCI PA and the CVS PA do not agree that the action or activity meets the definition of sexually aggressive behavior, the RCCI PA must elevate the decision to review with the Child Care Investigations Division Administrator. If no agreement can be made at the regional level, the RCCI PA elevates the decision to the RCCI State Office Director and CPS Director of Field.

• For the child who is determined to have sexually aggressive behaviors, document in the sexual aggression page in IMPACT:
  • The victim's name and PID.
  • Relationship to the victim.
  • The CLASS case number.
  • A description of the behavior.
  • The date of the incident.
If the victim child's case is from another region or PA area, the PA making the decision about the sexually aggressive child must discuss the concerns with the PA from the victim child's region to discuss child safety.	

CPS Protocols	RCCI Protocols

• For the child that is determined to be a victim of child sexual aggression, document in the special handling box:
  • The name and PID of the child who was sexually aggressive.
  • CLASS case number.
  • Description of the incident.
  • Relationship to the aggressor.
  • The date of the incident.	

The CVS PA notifies the PD, Supervisor, SSCC staff (if applicable), and CW of the decision, including the rational for the decision made.	
The CVS CW documents the decision to include or exclude the characteristic, and the rationale, in their narrative, entering it as a case staffing.	
If the child meets the definition of “sexually aggressive behavior” the CVS CW or SSCC staff (if applicable) • Launches a new application for placement. The new application for placement will autofill with the information from the sexual aggression page. • Documents the designation on the placement summary form (Form 2279) when a change of placement is needed. • Updates Child Plan of Service (CPOS) for both the child who was determined to have sexually. aggressive behaviors and the child who was the victim of child sexual aggression to include services and supports.	

CPS Protocols	RCCI Protocols
• Note: In Community Based Care (CBC) catchment areas, the placement summary is not required.	

CPI INVESTIGATION OF A KINSHIP HOME

INV Protocols	CVS Protocols
The CPI worker notifies CVS CW, KIN CW, and SSCC (if applicable) of intake.	CW is notified of investigation.
	CW reviews intake in IMPACT.
	CW immediately notifies supervisor of the investigation. CWs of alleged aggressor and victim maintain contact with the investigator and the child during INV to continue to assess child safety. CW must staff and take appropriate actions at any time to ensure the safety of the child sexual aggressor and/or the child victim.
	CW notifies parents and parties according to CPS Policy 6151.3.
INV notifies CW when the initial face-to-face interview with child is completed.	
	CW visits the child that is the alleged aggressor to see if supportive services are necessary and then arranges services immediately. (*CW does not interview the child about the allegations and does not inform the caregiver of the investigation.*) CW of victim visits the child to see if supportive services are necessary and then arranges services immediately.
	CW maintains contact with investigator during INV to maintain assessment of child safety.

INV Protocols	CVS Protocols
INV works with CVS CW to refer the victim child to CAC for a forensic interview, if necessary.	CW works with INV to refer the child to CAC for a forensic interview, if necessary.
INV notifies CVS CW and KIN CW of case conclusion.	
	CW notifies supervisor and PD about investigation findings.
	CW reviews the investigation in IMPACT.
	If the findings include the discovery of sexually aggressive behavior, the CW notifies the PA by email as soon as possible, but no later than 24 hours and copies the supervisor and PD. The CW includes the child's name, the child's PID, and the child's DOB.
	CVS PA reviews the investigation and the Child Sexual Aggression Guidelines as soon as possible, but no later than 24 hours to determine if child's behavior meets the definition of sexually aggressive behavior. If the behavior does not meet the definition of sexual aggression, the PA documents the staffing in a contact narrative.

INV Protocols	CVS Protocols

	The CVS PA documents the rationale in IMPACT
	
	• In the SUB stage for the child with sexual aggression document on the sexual aggression page:
	  • The victim's name and PID.
	  • Relationship to the aggressor.
	  • The IMPACT case number.
	  • A description of the behavior.
	  • The date of the incident.
	• In the SUB stage for the victim child document in the special handling box:
	  • The name and PID of the child who was sexually aggressive.
	  • Description of the incident.
	  • Relationship to the aggressor.
	  • The date of the incident.

	The CVS PA notifies the following people of the decision, including the rationale for the decision made: • Investigation Supervisor. • CVS PD. • CVS Supervisor. • CVS CW.

INV Protocols	CVS Protocols
	CW documents the decision to include or exclude the characteristic and the rationale in their narrative, entering it as a case staffing.
	If the child meets the definition of "sexually aggressive behavior" the CVS CW or SSCC staff (if applicable) • Launches a new application for placement in IMPACT. The application for placement will autofill with information from sexual aggression page. • Documents the designation on the placement summary form (Form 2279) when a change of placement is needed. • Updates Child Plan of Service (CPOS) for both the child who was determined to have sexually aggressive behaviors and the child who was the victim of child sexual aggression to include services and supports. Note: In Community Based Care (CBC) catchment areas, the placement summary is not required.

CPS PLACEMENT PROTOCOLS FOR ALL PLACEMENTS

*Note: In Community Based Care (CBC) catchment areas, the Single Source Continuum Contract (SSCC) staff will review the applicable forms and IMPACT documentation to recommend the best placement for the child. The caseworker will follow the placement process as outlined in the relevant CBC Operations Manual.

CPU and RTPC	Caseworker
	CW receives a discharge notice or requests discharge.
	CW reviews the child characteristics page on the child's person detail and reviews any documentation in the child sexual aggression page.

CPU and RTPC	Caseworker
	CW reviews the special handling window to see if there is any information about the child being a victim of sexual aggression.
	• Launches a new common in IMPACT. The new application for placement will autofill with information from the child sexual aggression page.
	CW submits placement packet.
Receives application for placement (Form 2087 or 2087ex), psychological evaluation and CANS, if applicable. Follow the placement process guidelines, including the requirements listed regarding the placement packet.	
Reviews application for placement to see if sexual aggression information is included.	
Reviews IMPACT child characteristics under the child's SUB stage to see if any incidents of sexual aggression are documented on the child sexual aggression page.	
Reviews the special handling window of all children to review documentation regarding children who have been victims of sexually aggressive behavior to ensure appropriate placement decisions are made for both a child who has been sexually aggressive as well as a child who has been a victim of sexually aggressive behavior. Check placement log to ensure an aggressor is not being placed with his/her victim. Conversely, check placement log to ensure a victim is not placed with his/her aggressor.	

CPU and RTPC	Caseworker
Provides name of placement(s) that accepted the youth for caseworker to consider.	After the CW selects the most appropriate placement, the caseworker: • Ensures the 2279 is updated. • Provides the 2279 to the caregiver at the time of placement. • Discusses supervision and services for the child while in placement. • Documents the plan for supervision in the Child Plan of Service (CPOS).

WHEN A CHILD WITH SEXUAL AGGRESSION RESIDES IN A KINSHIP HOME

Prior to Placement

Caseworker	Kinship Development Worker
Caseworker completes the appropriate section of the Kinship Assessment Referral form (form 6581) and provides specific information about the child's behaviors and need for supervision. See CPS Policy 6623.	
Supervisor reviews the completed home assessment to ensure the caregiver can meet the child's need for supervision and therapeutic interventions. If there are any concerns but the placement is approved, the Supervisor outlines concerns on the home assessment and forwards it to the Kinship Development Worker (KDW).	
	KDW reviews the home assessment and includes any identified concerns in the Kinship Development Plan.
At the time of placement, the CW reviews the 2279 with the caregiver, discusses supervision and needs, and develops a plan to ensure safety.	

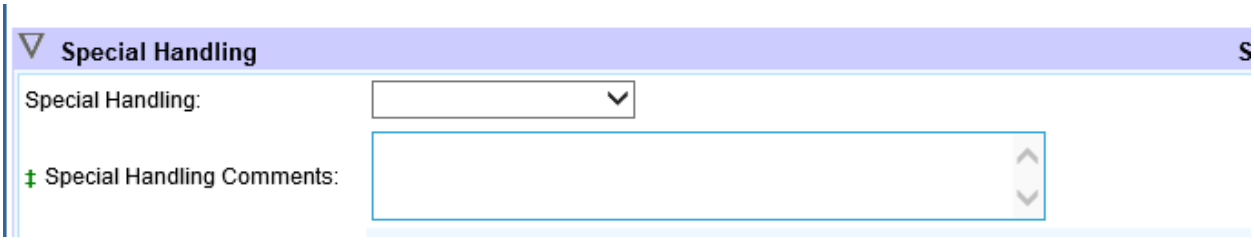
During Placement

Caseworker	Kinship Development Worker
CW follows the protocol outlined in the above section titled: CPS INV of a Kinship Home.	KDW discusses supervision and needs with caregiver to ensure the caregiver is aware of the child's behaviors and has the support necessary to ensure safety and success in the placement.

CHILD CHARACTERISTICS AND THE APPLICATION FOR PLACEMENT

If a CVS PA determines that a child demonstrates sexually aggressive behaviors, the PA documents the sexually aggressive behavior on the child sexual aggression page in IMPACT. The application for placement automatically pre-fills with the corresponding question marked "yes" and the description of the incident. This happens only when a new application for placement is launched; therefore, **staff must launch a new application for placement after a decision about Child Sexual Aggression is rendered**.

A child in CPS conservatorship who is a victim of Sexual Aggression should have this indicated in the special handling box in IMPACT, along with the name and PID of the individual who victimized the child or youth.



IMMEDIATE INTERVENTION & RESPONSE

ROLE OF THE LOCAL CHILDRENS ADVOCACY CENTER

1. A local children's advocacy center (CAC) forensic interview may be appropriate to assist CPS and/or law enforcement in identifying whether an alleged child has been abused or neglected prior to the identified sexual aggression.
2. The CAC forensic interview of the child victim should be used to inform the CVS PA and CPS/RCCI caseworker's evaluation of what occurred in cases with a potential child with sexual aggression.
3. The local CAC facilitates regular case review meetings during which CPS can discuss their cases and share information with law enforcement and other CAC multidisciplinary partners, per Texas Family Code 264.408.
4. A CAC may be able to help CPS determine whether there are any immediate safety concerns related to self-harm or suicidal ideation via appropriate assessment.

SERVICES & SUPPORTS FOR CHILDREN WITH SEXUAL BEHAVIOR PROBLEMS AND/OR SEXUALLY AGGRESSIVE BEHAVIOR

Services and supports for children with sexual behavior problems and/or sexually aggressive behavior must be two-fold, to address both the sexual behavior problems (and potential

accompanying sexually aggressive behavior) and possible abuse or trauma the child may have experienced before or after the incident.

TREATMENT FOR CHILDREN WITH SEXUALLY AGGRESSIVE BEHAVIOR

Studies support the belief that most sexually abusive youth are amenable to, and can benefit from, treatment. Children who act out sexually, despite their acts, need to be viewed compassionately and with a hopeful attitude toward recovery. These children are often victims of maltreatment themselves and deserve a chance to heal and live a healthy life.

One of the reasons treatment of sexualized behavior is so essential is because of a recently recognized phenomenon called the victim to offender cycle. Both male and female victims are at risk for this problem. Many offenders begin as victims, whose response to sexual abuse is to identify with the aggressor and to sexually act out in order to cope with their own sense of vulnerability and trauma. Professionals must recognize the potential danger of allowing sexualized behavior to go untreated-- the child then is at risk for becoming first an adolescent offender and at risk to eventually become an adult offender. The child not only damages him or herself, but also may cause grave harm to other children over the course of time and perpetuate the cycle of sexual abuse.

IMMEDIATE GOALS

1. Be sure the child is not being sexually abused or abusing others.
2. Report any/all incidents of sexual abuse to all parties involved.
3. Provide “sight and sound supervision” at all times.
4. Involve relatives, parents and caregivers when appropriate in the child’s therapy to participate and support the child.
5. Follow a written safety plan at all times.
6. Refer for psychiatric and/or medical evaluations when needed.
7. Collaborate with school, daycare, or after school care personnel.

APPROPRIATE TREATMENT GOALS

Below are some examples of appropriate treatment goals for children with sexually aggressive behaviors. The goals vary based on age and development, as does the level of involvement by the caregiver. Generally, the younger the child, the more critical it is for the caregiver to be involved in the treatment goals. The caseworker should work with the child's therapist to develop the treatment goals and ensure those goals are outlined in both the child's treatment plan and the child's plan of service. If the child does not have a therapist, the caseworker must arrange for one immediately.

1. Decrease the child’s sexually aggressive behaviors. These may include: persistent, intrusive and recurrent sexual thoughts; sibling incest; impulse control; aggression; and power and control issues.
2. Increase the child’s understanding of his or her unhealthy associations and beliefs regarding sex and sexuality. For example, sex equals secrecy; sex equals dirtiness, filth, shame, guilt; sex is “nasty”; sex equals love and caring; where and how to get nurturing.

3. Teach the child about the differences between “Ok touch“, “not Ok touch“, and “secret touch. “
4. Increase the child’s awareness of his or her own and family patterns that precipitate, sustain, or increase sexually abusive and other non-adaptive behaviors. For example: physical battery in the family; alcohol and drug abuse; role definition in the family; role reversals; parentified children; family scapegoats; family favorites; sibling rivalry; sociopathic tendencies of the family; consequences of actions.
5. Provide support and teach the child’s caregiver behavior management techniques for sexual behaviors and other problematic or disruptive behaviors which can involve rewarding "sex-free" days and using "time-out." This also helps channel energies that might have become sexual behavior into more age-appropriate activities by having a caretaker monitor the child, interrupt any sexual acting out, and provide opportunities for positive alternative behaviors.
6. Help the child understand and regulate his or her feelings and thoughts connected with prior victimization including physical, sexual, and emotional abuse; abandonment; neglect; family breakups; and deaths. Areas to focus on may include: secrets; nightmares; safety; responsibility for abuse; abuse reminders; Post Traumatic Stress Disorder (PTSD) symptoms; dissociation; boundaries: emotional, physical, and sexual; feelings about offenders; and damaged feelings. Provide support to the caregiver to assist the child with managing his or her feelings and thoughts.
7. Help the child make appropriate choices and decisions including practicing behaviors in everyday activities. Provide support and teach the child’s caregiver strategies to help the child with these choices and behaviors.
8. Develop with the caregiver and the child a detailed and specific long and short term safety plan. This includes recognizing that it is normal that there may be times of inappropriate thoughts/impulses etc., and that it is acceptable to talk about and not be afraid or ashamed to ask for help in coping. Emphasize that this shows good decision making /choices (a life preserver) and paradoxically a sign of real strength. Caregivers and other supportive adults should be involved in developing the safety plan.
9. Help the child learn and demonstrate skills to calm and reduce stress. Integrate these behaviors into everyday situations. Identifying and participating in some outside social/athletic/educational activity which matches the youth’s interests/abilities should be a requirement before treatment completion.
10. Help the child observe and assess his or her own behaviors, be aware of the circumstances preceding those behaviors, and think of the consequences of those behaviors before he or she acts.
11. Increase the child’s ability to observe and appreciate other people’s feelings, needs, and rights, with exercises related to victim empathy and moral development
12. Help the child understand his or her needs and values and develop his or her own goals and internal resources.
13. Increase the child’s ability to meet his or her needs in socially appropriate ways.

CAREGIVER AND ADULT RESPONSES TO CHILDREN WITH SEXUALLY AGGRESSIVE BEHAVIOR

It is extremely important to note that much of the shame and psychological damage that occurs--not only with child victims of sexual abuse, but also with sexually reactive children--stems from the reactionary behaviors of adults.

When first dealing with sexually aggressive children, caregivers, parents and adults should:

1. Attempt to remain calm in the presence of the children.
2. Phone a specialist or mental health professional immediately.
3. Talk to the child, without expressing anger, and inquire about where the child learned the behavior.
4. Do not punish or hit the child, as the child may not have known what he or she was doing was wrong. This would only result in an intense level of shame, which could carry over for years.

SPECIFIC HOUSE RULES FOR A CHILD WITH SEXUALLY AGGRESSIVE BEHAVIORS

These house rules can be shared with the caregiver and potentially used in service planning with the child and caregiver.

1. No sharing of bedrooms. If children must share bedrooms, get permission from their therapist.
2. Talk to the other children in the house: what to do if this happens and how not to become involved. Children need to be told that it is important to tell adults so adults can help with feelings and behaviors. Ensure there is proper safety planning in place.
3. Teach children specific skills to reduce anxiety or arousal. A time out, to repeat a phrase in his or her head, to engage in physical activity other than sex, or to draw or write out his or her feelings. The child must be given the tools to channel anxiety, frustration, anger or fear into appropriate, non-abusive activities.
4. Talk openly about rules about touching and what is appropriate. Talk openly and often about appropriate touch, safety, and boundaries with all the children in the family. Abuse happens in secrecy, so make sure everything is open and everything can be talked about. The more open you can be about sexuality and communication, the more likely a child is able to integrate what you are trying to tell him or her. Talking openly about the rules lets everyone know that sexual touching will not be kept a secret.
5. Work closely with the therapist to avoid misunderstandings and to reinforce therapy work at home.
6. Have a plan to address behaviors when they happen. Don’t ignore, don’t punish, and don’t shame. Address it calmly, assertively and immediately. Help the child to act appropriately.
7. Encourage self-esteem and age appropriate activities. When children feel less anxious, more in control and are exposed to more age appropriate activities and peers, the sexually acting out behaviors will usually decrease in frequency.
8. Use motion sensors for increased supervision.

Intervene when a child is sexually acting out or being sexually inappropriate by using the following four steps:

- Stop the behavior.
- Define the behavior.
- State the house rule.
- Enforce consequences or redirect the child.

TREATMENT FOR CHILDREN WITH SEXUALLY AGGRESSIVE BEHAVIOR

- Treatment options range from basic psycho-education to cognitive-behavioral therapy (CBT) to in-patient licensed sex offender treatment.
- It is important to initially evaluate with a therapist the length of the services or treatment program needed and communicate those expectations to the child and caregivers.
- It is also necessary for a treatment provider to re-assess the child to determine whether the chosen form of treatment is making a positive impact and whether additional services and supports are necessary.
- CACs provide trauma-focused cognitive-behavioral therapy (TF-CBT) at the CAC, off-site with a CAC provider, or via a community provider. If a CAC is involved, the CAC can assist in assessing and providing appropriate clinical services, as necessary. Note: Local CAC working protocol, case acceptance criteria, and/or capacity may dictate whether these services are available at your local CAC.

It is important for the caregiver(s) to be involved in any services and supports provided, as appropriate. It may also be beneficial for the caregiver(s) to be involved in related clinical sessions, both independent of the child and with the child as determined by the clinician. This will ensure that everyone understands their role and the plans for the children and will establish common expectations of all involved. This will also facilitate healing for everyone involved.

QUESTIONS FOR CAREGIVERS REGARDING SEXUAL BEHAVIORS IN CHILDREN

What to ask	Why to ask
When did someone first notice the behavior? Have there been any recent changes or stressors in your family? Have there been any new relationships or access to new individuals?	The behavior may be related to a recent stressor, such as a new sibling or parent separation.
Does the behavior involve other persons?	Most sexual behavior problems involve other persons.
How often have you seen the behavior? Is the frequency or nature of the behavior changing?	Escalation in the number or frequency of behaviors may indicate increased anxiety or stressors contributing to the behavior.
Can the child be easily distracted from the behavior? How do you (the caretaker) respond to the behavior?	Normative behavior is usually easy to divert; caretaker distress may escalate the behavior.

What to ask	Why to ask
Does behavior occur at home, school/day care, or both?	If occurring only at home, the behavior may be related to stressors, supervision, or changes at home, or the behavior may be related to differences in observer perception.
If the behavior involves another person, how old is the person?	It is important to determine if the behavior is occurring with someone in their peer group. Sexual behaviors involving persons much younger in age or less powerful are generally considered inappropriate.
Is the activity disruptive, intrusive, coercive, or forceful?	Disruptive, intrusive, coercive, or forceful behaviors are abnormal.
Does the child become anxious or fearful during the behavior? Has the child been diagnosed with emotional or behavior problems?	Sexual behavior problems in children have been associated with conduct and other behavior disorders.
Is there any violence among persons living in the home?	Intimate partner violence has been associated with sexual behaviors in children.
Does the child have or has the child had access to sexual material, acts, or information, including pornographic movies or images, nudity, Internet chat rooms, and texting that includes sexual language?	Children may mimic what they see or hear.
Has anyone ever spoken to the child about possible abuse?	Sexual behaviors in children are associated with physical abuse, sexual abuse, and neglect.

http://hopehealgrow.org/children-with-sexual-behavior-problems-what-is-normal-and-what-is-not/