

Assessing Children's Sexual Behaviors

The Child Sexual Behavior Checklist (CSBCL) *Second Revision*

Objectives:

- To gather data on the child's sexual behaviors from all recent caregivers.
- To ascertain if the child has a sexual behavior problem.
- To provide baseline data on a child's sexual behaviors against which data gathered at a later time can be compared.
- To help caretakers understand the types of information which they should report to treatment providers.
- To provide the data necessary to develop a plan to modify problematic sexual behaviors, if they exist.

Materials:

CSBCL – Second Revision – Parts I, II, III, IV

Nine Factors of Part IV of the CSBCL

Rationale and Purpose:

The Child Sexual Behavior Checklist (CSBCL) was specifically developed as an assessment tool for children twelve years and younger referred for sexual behavior problems. The CSBCL offers a descriptive history or summary record of a child's sexual behaviors from the perspective of the parents/caregivers. When treatment related to sexual behavior problems will be implemented, it provides the baseline data from which to develop a treatment plan. Many professionals use it as an intake tool for children receiving treatment for sexual abuse. It provides a framework for discussion with the parents/caretakers and alerts them to behaviors to be brought to the attention of the therapists during the course of treatment. The CSBCL can be used as a baseline for determining a child's functioning when entering foster, group, residential care or inpatient treatment. Without specific questioning and documentation, the sexual behaviors of children often remain obscured due to adult caretakers' reticence to discuss the issue. Out-of-home caretakers of children often need to be sensitized to children's potential problem areas.

When children are engaged in problematic sexual behaviors, it is often difficult for their caretakers to remember all of their sexual behaviors. A checklist provides the behaviors and the caregiver need only remember if the behavior is present. Some caregivers are embarrassed to use vocabulary about sexual behaviors or may worry about the proper terms to use. A checklist assists them to overcome these potential difficulties.

If problematic sexual behaviors are to be modified, it is important to know the behaviors in which the child is engaging prior to embarking on a treatment process. After a period of working on the child's sexual behaviors, the CSBCL can be completed again and compared with the initial checklist to develop a further plan of modification, if necessary. Often, as the first sexual behavior is worked on with the child and parents/caretakers, the other problematic sexual behaviors drop away. (Johnson, 2011b)

Using the CSBCL:

Administering the CSBCL

This instrument may be difficult for some parents to complete. For this reason it is not advisable to send this checklist to be completed at home. If there are two parents, each should complete it separately and at the same time in an office setting. If there are two parents and not all want to complete the CSBCL, let them know that this is not in the child's best interest. Each parent will give a valuable perspective on the child's sexual behaviors. Advise the parents that each person's perception and knowledge of the child's sexual behaviors is important. Parents should not discuss the CSBCL while they are completing it.

Go over the instructions *carefully* to Parts I, II, III with the parents and go over the first few questions with them to assure they are completing the form correctly. Then, if possible, put respondents in separate rooms or have someone overseeing them so they do not collaborate on the answers. After completion of the first three parts and review by the therapist/evaluator, a determination is made about the use of Part IV.

If the child is in foster care it is essential that both foster parents complete the CSBCL. This is just as important as having both biological parents fill it out. Young children's behaviors often emanate from the environment in which they live and can be fostered or reduced by their parents. The parents will be key to assisting the therapist/evaluator in understanding what is occurring in the home, extended family and neighborhood and later will be instrumental in modifying any concerning sexual behavior.

If the child is in a group home or a residential facility, it will be most useful to get a staff person on each shift to fill out the CSBCL. If weekend staff is different, a weekend staff person's view will also be important. If the child has a therapist, the therapist should also fill out the CSBCL. Instruct the staff and therapist that each should fill out the CSBCL separately without discussing it with the others. In some locales, you may need the permission of the child's social worker.

For some children it may become important to gather additional information if certain parts of the child's life have not been surveyed and the child is engaging in problematic sexual behaviors in those areas. Sometimes it is important to get information from the child's school, day care, baby-sitters, or relatives. Ask the parents/caretakers permission before asking other people to complete the CSBCL

There are four parts of the CSBCL. Part I of the CSBCL contains over 150 behaviors of children related to sex and sexuality ranging from natural and healthy childhood sexual exploration to behaviors of children experiencing severe difficulties in the area of sexuality.

Behaviors related to toileting are included as these may be part of the clinical picture of a child with sexual behavior problems. The behaviors are grouped by type for ease of recall. Part II asks about aspects of the child's life which might increase the frequency of sexual behaviors, e.g. access to pornography, nudity, Internet, abuse history, sleeping arrangements and whether the child has seen violence between people he or she knows. It should be evaluated for potential factors, which can be modified to decrease sexual behavior problems.

Part III provides information about behaviors the child engaged in with other children. What were the ages and gender of the children with whom the child engaged in the behaviors? How did the child get the other child/ren to engage in the behaviors? What is the child's affect around sexual behaviors, especially when confronted? Question 6 on page 9 asks: "Child has a sexual problem." Five possible answers are suggested. This is a very important question to assess across respondents.

Part IV is comprised of 26 characteristics of children's behaviors related to sex and sexuality that raise concern. This part is completed with the respondents and the therapist/evaluator. The seriousness of the child's sexual behavior problems increases in direct proportion to the number and type of the characteristics that fit the child's sexual behaviors. There are nine factors derived from the 26 characteristics.

Reviewing the CSBCL with Respondents

The most satisfactory way to start to interpret the CSBCL is for the therapist/evaluator to have time to look at the completed CSBCLs prior to reviewing it with a respondent or a group of respondents. Once the therapist/evaluator has reviewed the CSBCL/s, a thorough interview with the respondents will be most fruitful. Please see, *Reviewing And Interpreting The CSBCL After All Necessary Respondents Have Completed It* on page 7 below.

Review the first three parts of the CSBCL with the respondents, going over the more elevated scores and those that have been going on a long time. If multiple parent/caretakers have completed the CSBCL, it is best to review the CSBCL's all together. This is an excellent way to assist the parent/caretakers to think about the behaviors and become more comfortable talking with you about the child's sexuality and sexual behaviors. The CSBCL can be duplicated so each person has a copy to look at while the therapist goes through it and asks about elevated scores. If there is a disagreement between the respondents, discuss this. Important information can be garnered during these discussions. The parents' attitudes, perceptions, biases, and disagreements often come through in these discussions. Understanding the parents/caretakers through this process can illuminate where there are difficulties in the family and assist the therapist to develop strategies to help the child and family. If the CSBCL has been done in a group home or residential facility, the therapist/evaluator should gather the respondents at the group home and review the first three parts with them.

Part IV should be used if, after reviewing the responses of all respondents to Parts I, II, and III the child appears to have some concerning sexual behaviors. Part IV should be done with all respondents together, whenever possible. Explain the rating scale to the respondents and then read each characteristic. Ask the respondents how much this

characteristic typifies the child's sexual behavior and ask for examples. This process will further illuminate your understanding of the child and the child's caretakers as related to the sexual behaviors and the family relationships/environment.

Issues To Bear In Mind While Interpreting The CSBCL:

Adult Versus Child Sexuality

It is tempting to think that all children's sexual behaviors, which look like adult sexual behaviors are in fact experienced in the same way by children as by adults. This is generally not the case, yet it is true in some cases. While some children experience sexual arousal, sexual orgasm, sexual pleasure and sexual fantasies, these are generally not experienced by prepubertal children. The influx of the sexual hormones produces the drive for sexual (orgasmic) contact with one's own genitals and those of others. This cascade of the hormones occurs at different ages. Adult and adolescent sexual behaviors have at a basic level sexual drive and pleasure. Do not assume this in childhood sexual behaviors. It is sometimes present but for the most part it is not. It is preferable to use the term or think in terms of "behaviors related to sex and sexuality" rather than "sexual behaviors" for young children. This helps assessors not confuse adult and child sexuality.

"Natural and healthy sexual exploration during childhood is an information gathering process wherein children explore each other's bodies, by looking and touching (e.g. playing doctor), as well as explore gender roles and behaviors (e.g. playing house). Children involved in natural and expected sex play are of similar age, size and developmental status and participate on a voluntary basis. While siblings engage in mutual sexual exploration, most sex play is between children who have an ongoing mutually enjoyable play and/or school friendship. The sexual behaviors are limited in type and frequency and occur in several periods of the child's life. The child's interest in sex and sexuality is balanced by curiosity about other aspects of his or her life. Natural and expected sexual exploration may result in embarrassment but does not usually leave children with deep feelings of anger, shame, fear or anxiety. If the children are discovered in sexual exploration and instructed to stop, the behavior generally diminishes, at least in the view of adults. The feelings of the children regarding the sexual behavior are generally light-hearted and spontaneous. Generally, children experience pleasurable sensations from genital touching, some children experience sexual arousal, while some children experience orgasm. Sexual arousal and orgasm are more frequently found in older children entering puberty." (Johnson, T.C. 2015 p. 1-2)

Respondents

It is not expected that two parents/caregivers who live with the child in the same home will provide the exact same scoring on each of the sexual behaviors, but the similarities should be greater than the differences. If one respondent says the child engages in a particular behavior four times or more a month and the other respondent says it never occurs, or only one time a month this will generally indicate a problem in the communication between the parents/caregivers or some other issues to explore. Smaller discrepancies can also be significant. Possible difficulties could be: If respondents are a couple, are they polarized regarding their own sexuality or sexual relationship and this is being played out in rating the child's behaviors? Is one parent/caregiver increasing the frequency of the child's

behavior to bring more attention to the behaviors because the other parent/caregiver is denying the behavior? Is there embarrassment at the child's behaviors, difficulty discussing sexual issues, a reluctance to acknowledge problems of any kind? Is there any current or past abuse which is being covered up? Is there a tendency to augment or decrease the child's sexual problems by one parent due to a divorce/custody situation?

While evaluators/therapists may be more reluctant to scrutinize the answers of foster parents as closely as those of a child's parents, this is important to do. Being a foster parent is very difficult. Foster parents, like biological parents, have their own histories and present life circumstances that may compromise their ability to see the child they are caring for in an objective light. There are significant strains put on foster parents' relationships when they care for a foster child. Foster parents may have strong feelings about the parents of the foster children for whom they are caring. This can cloud their objectivity.

There are a variety of things that may account for large differences between respondents' answers on the CSBCL when a child is in out-of-home care. Are observations different due to the child behaving differently in the presence of men vs. women? Are some respondents more accepting of the child's sexual behaviors and therefore the child engages in more behaviors when the child is with them? Is there a respondent who the child takes advantage of and engages in behaviors to shock, embarrass or bother the respondent? Do any respondents disagree with the rules of the residence and subtly foster the child to engage in more behaviors related to sex and sexuality? Does the time of day the respondent is with the child account for the different type and level of sexual behaviors? Are there some locations that elicit more or fewer behaviors related to sex and sexuality? Do any respondents have a reason to deny or minimize the child's behaviors? Is discussing sexual issues considered crude, embarrassing or unacceptable? Is there a reason not to tell the truth? Is there something to hide? In one study it was discovered that residential care workers (line staff) listed fewer sexual behaviors on the CSBCL than the social workers. One reason for this was that the workers had not always written incident reports and therefore did not fill out the CSBCL accurately for fear they would be asked why the behaviors had not been previously reported. (Johnson, 1993)

There are other things to keep in mind regarding respondents. Some respondents: do not like filling out an inventory of sexual behaviors, do "not want to reduce the child's behavior to paper, pencil and tick marks" thus dehumanizing the child, some become agitated and/or overwhelmed by the list of sexual behaviors, some do not want to take the time, some do not see the task as valuable. Embarrassment can be an issue, and revulsion at the idea that children might behave in these ways related to sex and sexuality can all affect the reliability and validity of their responses.

It may seem that since it is hard to get objective data that is valid and reliable, it is not useful to use the CSBCL. On the contrary, it makes it all the more important to gather the data and look at it in an organized fashion so that any misperceptions, distortions and inconsistencies can be ironed out in order to understand the child who has been brought for assessment. Data gathered on the CSBCL is essential for developing a treatment plan, if one is necessary.

Pay Close Attention To The Context Of The Sexual Behavior

The behaviors related to sex and sexuality in which children engage obviously do not occur in a vacuum. It is important to take into account as many of the contextual factors as possible so that the child's sexual behavior will be understood accurately.

Some of the things you want to keep in mind while assessing a child's behaviors related to sex and sexuality:

How do the parents react to the child when he/she engages in the behavior? Is the child consistently discouraged from engaging in problematic sexual behavior or do people reinforce the behavior through laughter or lack of limit setting?

What are the parents/caretakers' overall expectations of the child in relation to the sexual behavior, which may influence the child's behavior?

Do the parents/caretakers engage in the same kinds of behaviors?

What are the boundaries in the home that may be affecting the child's behaviors?

Is there emotional, physical or sexual abuse occurring to the child or others in the home/environment of the child?

Are there role models for the behaviors in which the children are engaging? (children, teenagers, adults either in the home or neighborhood, nannies, babysitters)

What is the child's motivation to engage in the sexual behavior?

What was the child/ren's affect when engaging in the behavior?

What was the child's experience when engaging in the behavior? (Positive, negative, neutral)

How was the behavior discovered, by whom, what did the person do/say?

Are the child's behaviors mainly alone or with others? (children, teenagers, adults)

What is the relationship between the child and others who are engaging in the behavior?

Is one of the children especially (emotionally or physically) vulnerable who has been involved in the sexual behavior?

If a child engages in solitary behaviors, where does the child do them? If several children are engaging in sexual behaviors, where were they doing and why was this place chosen?

Do you have adequate information? Do you need other people to answer the CSBCL? If the behaviors are occurring outside the home, do you need to ask teachers or day care personnel to complete the CSBCL? Do nannies or babysitters need to be interviewed?

Are the behaviors mostly current, before the last three months, are they continuous, do the behaviors cluster in some categories?

Are the respondents seeing basically the same behaviors or widely different? Are the behaviors all happening in the same location?

Are the behaviors more akin to behaviors that might be engaged in during childhood (Johnson, 2015) or behaviors generally done by adults?

Is the child's behavior so highly supervised and restricted that even natural and expectable behaviors are seen as problematic? (This can happen in foster, group and residential settings where all sexual or seemingly sexual contact between children is not allowed.)

What are the other behaviors of the child? Is the child generally dysregulated? Does the child have psychiatric or medical diagnoses that may be contributing?

Reviewing And Interpreting The CSBCL After All Necessary Respondents Have Completed It:

Part I

Part I has 150 behaviors related to sex and sexuality in children 12 and younger. The list below is a subset of the 150 behaviors. These are behaviors that occur more commonly in children 12 and younger. These behaviors are generally not problematic but can be if they have some of the 26 characteristics listed in Part IV.

Commonly Occurring Sexual Behaviors

- A.1. Shows interest in how babies are made.
- A.2. Talks about wanting to have a baby.
- A.3. Asks questions about sex.
- A.4. Shows interest in physical differences between girls.
- A.5. Asks why girls don't have penises.
- A.6. Talks about opposite sex children in a negative way.
- A.7. Sex and/or romance are part of the child's play.
- A.8. Likes to watch sexual activity on TV, videos or in movies.
- A.11. Plays "house" with children.
- A.12. Plays "doctor" or "hospital" with children.
- B.2. Asks for hugs / hugs adults.
- C.1. Masturbates while alone.
- D.1. Acts like parent to brothers and sisters.
- D.2. Acts like parent to other children.
- E.1. Uses sexual swear words in a playful, giggly way.

- G.1. Refuses to bathe with others.
- J.1. Does not want to undress in front of others.
- J.6. Tries to see other people nude.
- L.1. Tells “dirty” jokes.
- L.3. Talks about sex/sexual things with friends.
- L.4. Talks in a romantic fashion about children.
- Q.3. Kisses / tries to kiss adults in the family.
- S.1. He briefly grabs own penis when scared, sleepy, or excited.
- U.1. Has specific words for own “private parts”.
- U.2. Thinks men/boys are smarter and better than women/girls.
- U.3. Thinks women/girls are smarter and better than men/boys.

Who has completed the CSBCL? What is the respondent’s relationship to the child? Which respondent is likely to have the best knowledge of the child's sexual behaviors? Do you have information from all of the places the child is engaging in sexual behaviors? Do you need to interview some other people? Do you need more people to complete the CSBCL?

Note the number and type of sexual behaviors in which the child has engaged. Look at the "current" sexual behaviors. These are the behaviors in the last three columns. Look at the behaviors with the highest frequency. Are these high frequency behaviors worrisome or are they within normative limits for the child’s age? Do the high frequency behaviors cluster? Are all or only some respondents seeing the behaviors? Are there certain settings where the high frequency behaviors are occurring most? Are there other respondents who could provide further information about the behaviors in question? Is there any reason to question the accuracy of the respondent/s?

Are the solitary behaviors natural and healthy for the child’s age? If not, are there reasons to help understand elevated problematic solitary behaviors? Is there anything about the location in which they are occurring which is important to assess? Is the child engaging openly in the behaviors? Is the child unable to get privacy to engage in acceptable solitary sexual behaviors for his or her age? What is the response of the caregivers when they discover the behavior? Is this encouraging or discouraging the behavior? Part IV will provide information regarding problematic characteristics of the behaviors.

Is the child engaging in sexual behaviors with other children? Are they natural and healthy for the child's age? Is there anything about the location in which they are occurring which is important to assess? Is the child engaging openly in the behaviors? Are the behaviors those that are more expectable or would children be more likely to hide them? Is the child's behavior so highly supervised and restricted that even natural and expectable behaviors are seen as problematic? (This can happen in group and residential settings where all sexual or seemingly sexual contact between children is not allowed.) What is the response of the caregivers when they discover the behavior? Is this encouraging or discouraging the behavior?

Are there differences in the child's behaviors between school, after school care, day-care, at the baby-sitters and at the child’s home? Differences may well be due to the location, children present, the structure of the environment, the adults present, etc. It may be important to review some of the ratings with respondents outside the home if the CSBCL was sent to them through the mail. If interventions need to be developed for any sexual

behaviors it will be essential to speak directly to all caretakers for the child to develop the interventions and understand the specific characteristics of the particular behavior in each setting.

Are the current behaviors related to sex and sexuality more or less frequent than those which "used to" occur? Are the new behaviors more problematic? If so, have there been changes in the child's care providers, the people with whom the child lives, the location in which the child resides? Has the child been exposed to adult sexuality?

Look at "used to" and "current." These are the behaviors that are more persistent over time in the child's repertoire. Are the child's observed behaviors increasing or decreasing? Are the "used to" behaviors greater than the current behaviors? See if there are vast discrepancies between respondents. Could discrepancies be related to the place the respondent sees the child? Do the longer term behaviors have more problematic characteristics or are they more commonly occurring?

If the "used to" behaviors were problematic, the evaluator/therapist should determine if these behaviors simply disappeared or whether there were successful interventions by adults to assist the child to discontinue the behaviors. If further intervention is necessary, information on how past behaviors were curtailed will be useful.

It is also possible that the child continues to do the "used to" behaviors but the current respondents do not know this. If it seems important, additional respondents who observe the child at different times or who can provide additional information can be asked to complete the CSBCL. If the "used to" behaviors are those that commonly occur in this age child, this may show a healthy movement on the child's part to be more secretive! Most children are secretive about natural and healthy behaviors related to sex and sexuality that parents do not want to see. Research indicates that approximately 90% of adults report that no adults knew about their sexual behaviors when they engaged in them as children. (Johnson and Mitra, 2007)

Part II

Part II will provide a view of the home environment. If the child's sexual behaviors are of concern, it will be useful to see if there may be a lack of privacy and healthy sexual boundaries in the home. Does the child sleep in his or her own bed, bathe alone, request assistance with bathing? Is there too much exposure to adult or adolescent sexuality? Has there been abuse or violence in the home? Has this been directed at the child, siblings, a parent, or another caretaker? How old was the child when abuse or violence occurred? How long did the child live in that environment? Was there violence that occurred in the context of sex? Has sex and aggression been paired in the child's environment? This is a factor frequently seen in the history of young children who engage in aggressive sexual behaviors.

Does the child have playmates? Are they older, younger, the same age, girls or boys? If the child is engaging in natural and healthy sexual behaviors with other children, it is generally the same age children with whom they regularly play. If they only play with older or younger children keep this in mind. They may not have access to same-age children.

Is Internet access available to the child? Be aware, almost all parents believe they monitor children's access when there is Internet available. Much of the time the parent is inaccurate. If a parent or caretaker watches sexually explicit material on the Internet, children often observe it at the same time with the parent's knowledge or without it. If the last Internet site watched is not discarded, children simply open up the browser and get the site. Older children in the home may enjoy the Internet and not shield younger children from the sexually explicit sites.

If further assessment of the boundaries in the home is important, see Family Roles, Relationships, Behaviors, and Practices VI (Johnson, 2007) and Family Practices Questionnaire VI (Johnson, 2002b) and VII (Johnson, 2004). (www.tcavjohn.com)

Part III

Part III provides information about behaviors the child engaged in with other children. What were the ages and gender of the children with whom the child engaged in the behaviors? Are they the same as the children with whom he or she regularly play? (See Part II.) Does the child know the other child/ren? It is very uncommon for children 12 and younger to engage in natural and healthy sexual behavior with children they do not know. How many children have been involved? How did the child get the other child/ren to engage in the behaviors? What is the child's affect around sexual behaviors, especially when confronted? It will be very useful to compare multiple respondents' answers to all of the questions and, in particular, the answer to the last question regarding whether the child has a sexual problem. If it appears that there are a substantial number of problematic behaviors but the respondent/s don't think there is any level of sexual problem for the child, treatment will be very difficult. If there are very few problematic sexual behaviors and the respondents indicate a serious sexual problem, this is a very important issue to assess. It will be essential to arrive at a shared view of the level of the problem and the goals of any interventions prior to providing any services.

Question six, Part III asks the respondent whether he/she thinks the child has a sexual problem. A respondent's reasons for believing a child has a sexual problem may be influenced if the child has been a victim of sexual abuse. Some adults ascribe more seriousness to a child's sexual behaviors if the child has been sexually abused. It sometimes occurs that two children engage in approximately the same types of sexual behaviors and the child who has been sexually abused will be given a more serious rating. If two children engage together in a sexual behavior, the child who has been sexually abused is more likely to be seen as the aggressor. While this may be true, it is as likely that it is not true. Without thorough investigation, this assertion cannot be made. Watch out for people's basic assumptions that children who have been sexually abused will become "perpetrators." There is no factual basis for this belief. Please read the section entitled, "Do Victims of Sexual Abuse Become Perpetrators of Sexual Abuse" on pages 34-35 in "Understanding Children's Sexual Behaviors, What's Natural and Healthy" (Johnson, 2015). (www.tcavjohn.com)

A respondent's reasons for believing a child has a sexual problem may be influenced if the child is in out-of-home care rather than living with his or her biological parents. Commonly occurring sexual behaviors can be pathologized if they occur in out-of-home care as virtually no sexual experimentation between children may be allowed.

If treatment for sexual behavior problems is indicated, the degree of correspondence between the caretaker's description of the child's sexual behaviors and his or her perception of whether the child has a sexual problem will be very important. The differences between respondents' answers are equally as important to evaluate as their similarities. It is critical that the caretakers and therapists have a shared understanding of the child's issues, level of sexual problem and agree upon treatment goals before engaging in therapy with the child and his/her parents/caretakers. If the caretakers, therapist and child do not all agree on the goals of the therapeutic interventions, the interventions will not work.

Part IV

Part IV will provide the therapist/evaluator with very helpful information regarding the level of sexual problems the child may have. Whereas the type and frequency of behaviors the child is engaging in are important, it is the problematic characteristics that make the behaviors more or less worrisome. While masturbation may not be a problem for one child and family, it may be for another child if the child can't stop himself or herself and doesn't understand boundary issues regarding the masturbatory behavior.

Certain behaviors related to sex and sexuality are not expected in children 12 and younger. These are penile penetration of the vagina or anus, digital penetration of the vagina or anus, or using the mouth to suck on or lick someone's penis or vagina. These are more akin to adult sexual behaviors and when sexual arousal and pleasure are involved. When these occur in children, it may be due to the children having observed this behavior in vivo or in the media, be it in movies or on the Internet, or having been the recipient of this type of behavior. In some 10 -12 year old children peer pressure can also come into play, as well as, puberty. Research indicates that by age 12, 2-4% of girls and 6-8% of boys have had sexual intercourse. (Brown et al., 2003) Therefore, while this behavior does occur in children 12 and younger, it is unacceptable to most adults. Sometimes in preschool children there can be experimentation with body parts that may look like adult sexual behavior, such as investigating parts that stick out and parts that things can go in. This may look like adult sexual behavior and be very concerning but it is not.

The 26 characteristics of children's problematic sexual behaviors that are provided in Part IV are to determine if the child's sexual behaviors deviate from those that are natural and healthy in children 12 years and younger. The background and foundation for choosing these characteristics is described on pages 17-22 in "Understanding Children's Sexual Behaviors – What's Natural and Healthy?" (Johnson, 2015) (www.tcavjohn.com). Also see the definition of natural and healthy sexual behavior in children on page 1-2 in this booklet.

In order to best assess the 26 characteristics of Part IV use the sheet provided at the end of this document entitled, Child Sexual Behavior Checklist Part IV Factors. The Factors are generally listed from the least to the most problematic, although Factor 2 may be paramount or more significant in some children, particularly children who have been overwhelmed by sexual experiences imposed on them. Using the answers provided by each respondent, check the characteristics on the document Child Sexual Behavior Checklist Part IV Factors (see p. 16-17 below) for each person. There are four boxes provided. Number the respondents. Use box 1 for the first respondent, box 2 for the second respondent, etc. In

this way you can more easily scan to see which respondents saw which characteristic in the child.

Look at the types and frequency of the most prominent of the child's sexual behaviors and determine how the characteristics interact with the sexual behaviors. Are more intrusive sexual behaviors characterized by the more serious characteristics? Be cognizant of the respondents' answers to the question about whether the child has a sexual problem (Question 6, Part III) while assessing the interaction between the characteristics and the actual sexual behaviors in which the child is engaging.

Look at the differences between respondent's scoring and statements about the characteristics of the child's sexual behaviors. Are differences between respondents due to the location the respondent knows the child from, the time of day the respondent sees the child, the accessibility of the child to other children while the respondent observes him or her, the structure of the setting in which the respondent sees the child?

Develop a mental picture that combines the types of behaviors from Part I in which the child is engaging, with the characteristics scored in Part IV. If the child is engaging in solitary behaviors does the child stop the behaviors only to start again? (Factor 4) If the child is engaging in sexual behaviors with other children, does the child seem to be aware of the conventions around sexual boundaries and the rights of others? (Factor 5) If the major area of problem behaviors for the child is sexual talk does the child not respond to limit setting? (Factor 4) Does the child seem very interested in the genitals of adults, tries to touch the sexual parts of others, seems to know more about sex and sexuality than other children? (Factor 1) Is the child constantly asking questions about sex, wants to see the baby's diapers changed, touching his or her genitals? (Factor 3) Is the child constantly touching his/her genitals in public despite being told repeatedly to stop? (Factor 5) Is the child forcing sexual behavior on another child who does not want it? (Factor 9) Does the child act like the sexual behavior is mutually agreed upon but it is not? (Factor 7) Is there anger involved with the sexual behaviors? (Factor 8)

Each characteristic and factor must be assessed in relation to the child's overall behavior. Would characteristics such as "Does not respond to limit setting," "disregard or objectification of others," be true for the child's overall behavior, not just the sexual behaviors? Is the problem related partially or entirely to sexuality? If the child is generally verbally belligerent and oppositional, is the use of sexual words in combination with the belligerence exhibiting a problem with his sexual development, or his overall development to which the sexual language is attached? Is anger pervasive in the child's behavior but not attached to the actual sexual behavior with another child? Is anger pervasive in the child's behavior and also attached to the sexual behavior with another child? If the child has a greater than expected emphasis on sexuality, does he or she also have a greater than usual emphasis on some nonsexual things? If the child has poor sexual boundaries, are the child's boundaries confused in other areas also? If the child appears to be impulsive about sexual issues, is this true of other behaviors of the child?

An important issue that arises in assessing a child's sexual behaviors is also assessing the child's other behaviors. Does the child have Attention Deficit Disorder and/or Attention Deficit Disorder with Hyperactivity? Does the child have an autistic spectrum disorder, a development disorder, anxiety, depression, disruptive behaviors, a conduct disorder, a

learning disability? Are other problems of the child driving the sexual behaviors? Are other problems of the child more salient or is the child's sexual development the more salient issue? What proportion of the problems comes from which of the child's issues? Are there problems in the family, between the parents, with siblings, at school, in the neighborhood, at after school program, with babysitters, nannies, coaches, teachers that may be driving the child's problems?

Assessing the degree to which the child has a behavioral problem versus the degree to which the child has a problem in his or her sexual development is essential so that a child's overall behavior problems don't cause the child to get a label as a "sexual problem child." It has certainly happened that a very angry and defiant or oppositional or conduct disordered child has engaged in one sexual behavior which could be considered problematic and was determined to be a child "who molests." This is unfair, unethical, and enormously damaging to the child's sense of self and his or her developing sexuality. One behavior does not make a child an offender, a deviant person or necessarily even a child with a sexual behavior problem. The problematic or worrisome behavior could have been the result of a dare, poor boundaries, a lack of understanding about the seriousness of the behavior, poor judgment, copying something the child saw on television, a video on the Internet or his/her parents' behavior, etc.

In order to determine the level of seriousness of the sexual behaviors we must look at the totality of the child and then assess the worrisome sexual behaviors (Part I) in relation to any problematic characteristics (Part IV). In order to say that a child is molesting other children there must be a pattern of behavior in which sex is used to hurt (emotionally or physically), take revenge, or demonstrate anger at the other person AND some or all of the problematic characteristics in Part IV under Factors 7, 8, and 9.

Each child is different and so it is not possible to say to what extent ("sometimes true" or "always true") the problematic characteristics listed as P, S, T, U, V, W, X, Z must be involved for a child to be considered a child who molests. These characteristics of the child's sexual behavior must also be seen in light of the child's overall behavior and relationships.

There are four groups of children 12 years and younger who engage in sexual behaviors. These groups are: Children Who Engage In Natural And Healthy Sexual Behaviors, Sexually-Reactive Children, Children Who Engage In Extensive, Mutual Sexual Behaviors and Children Who Molest Other Children. An understanding of this continuum of sexual behaviors in young children, good clinical judgment and extensive information about the whole child and his or her family will be important in determining which group the child belongs in and the elements of a treatment plan. A description of the four groups can be found in "Understanding Children's Sexual Behaviors, What's Natural and Healthy" (pp. 35-37, Johnson, 2015). (www.tcavjohn.com) Most children who have problematic sexual behaviors fall into Group II, Sexually-Reactive Children. There are very few Children Who Molest.

Evaluating All Of The Information Together:

After reviewing all of the material in the CSBCL, it should be clear if there are any concerns regarding the child's behaviors related to sex and sexuality. If there are a number

of behaviors or groups of sexual behaviors which require interventions, the treatment team (parents/caregivers, care providers in group homes or residential facilities, foster parents) should determine with the child and treatment provider the order in which the behaviors will be modified and how. It is most successful to pick one behavior which: occurs frequently, has a good possibility of diminishing or extinguishing, causes the child to be targeted for discipline, interferes with other children or makes the child a scapegoat for others' problems AND the child agrees to try to change. A fairly high frequency behavior allows the treatment team to interact frequently and positively with the child and both the team and child see progress. All elements of how to decrease problematic sexual behaviors in children are included in the Plan to Modify Problematic Sexual Behaviors and the Road Maps. Both are included in Treatment Exercises For Child Abuse Victims And Children With Sexual Behavior Problems. (Johnson, 2002a) Additionally, Helping Children With Sexual Behavior Problems – A Guidebook for Professionals and Caregivers (Johnson, 2016) (www.tcavjohn.com) is specifically designed for decreasing sexual behaviors. The therapist and the parents can each have the booklet and work together to help the child.

It is often helpful to have respondents fill out a behavior survey on the child such as the Child Behavior Checklist. (Achenbach, 2001) This can provide a guide to the general behaviors of the child. In some cases, the child has a substantial number of dysregulated behaviors and a concerted plan of intervention needs to be coordinated around sexual, as well as, nonsexual behaviors.

The CSBCL should be used in conjunction with a detailed interview of the child, his/her siblings, and parents/caregivers. Interviews with persons outside the family who are familiar with the child and family will provide an additional perspective, which will be helpful to the therapist/evaluator. Any previous reports on the child should be reviewed carefully. Psychological testing will give a broader view of the child's emotional state. Educational testing will provide a measure of intellectual and functional ability. Medical examination may also be required.

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All Johnson, T.C. books, articles and booklets can be found at www.tcavjohn.com

Child Sexual Behavior Checklist **Part IV Factors**

Put name of each respondent.

Box 1 _____

Box 2 _____

Box 3 _____

Box 4 _____

1. CHILD'S SEXUAL DEVELOPMENT IS DIFFERENT THAN SAME AGE PEERS.

- A. Engages in sexual behaviors with children who are quite a bit older or younger.
- E. Seems different than same-age children when it comes to sex.
- U6. Has an understanding of sex greater than would be expected for his/her age.

2. CHILD SHOWS ANXIETY GUILT AND/OR SHAME ABOUT SEX.

- N. Child feels fear or anxiety in relation to sexuality or sexual behaviors.
- O. Child feels guilt or shame in relation to sexuality or sexual behaviors.

3. CHILD HAS A GREATER THAN EXPECTED EMPHASIS ON SEX AND SEXUALITY.

- C. The child's sexual behaviors are a large, rather than a small part, of his or her life and daily activity.
- F. Engages in more sexual behaviors than other same-age children.
- U7. Seems overly interested in sex.

4. CHILD DOES NOT RESPOND TO LIMIT SETTING.

- G. Engages in sexual behaviors in spite of consistent and clear requests by adults to stop.
- H. Engages in sexual behaviors with child/ren despite the child/ren saying "no."
- I. Child appears to be unable to stop self from engaging in sexual behaviors.
- J. Child engages in sexual behaviors in public after being told not to do so.
- K. Other children complain about the child's sexual behavior or talk.

5. CHILD IS CONFUSED REGARDING SEXUAL BOUNDARIES.

- B. Engages in sexual behaviors with child/ren with whom he/she does not regularly play.
- L. Child's sexual behaviors are directed at adults who feel uncomfortable receiving them.
- M. Child (four years of age and older) does not understand his/her rights or the rights of others about sexual behaviors.
- R. Child sexualizes nonsexual things, interactions with others, or relationships.

6. CHILD SHOWS ADULT-LIKE SEXUAL BEHAVIORS.

- D. Child acts more like an adult than a child in relation to sex.
- Q. Child engages in extensive, persistent, mutually agreed upon adult-type sexual behaviors with child/ren.
- Y. Child engages in sexual behaviors that are becoming more frequent, more concerning and more intrusive over time.

7. CHILD DISREGARDS OR OBJECTIFIES OTHERS.

- T. Child uses "distorted" logic to justify sexual behaviors ("She didn't say 'no.'" "He didn't run away.")
- Z. Child shows a lack of empathy or caring toward the other child/ren involved in the sexual behavior.

8. CHILD HAS ANGRY FEELINGS ABOUT SEX.

- P. Child feels anger in relation to sexuality or sexual behaviors.
- U. Child uses bad language and/or acts angry before, during or after sexual behaviors.

9. CHILD USES COERCION OR HURTS OTHERS WITH SEX.

- S. Child engages in sexual behaviors that cause physical or emotional pain or discomfort to self or others.
- V. Child uses physical force before, during or after sexual behaviors.
- W. Child uses sex to hurt someone else.
- X. Child uses bribes, manipulation, threats, force or other coercive means to get another child to engage in sexual behaviors.