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Childhood Sexual Behavior:
An Integrated Developmental Ecological Assessment Approach

A Dissertation

Presented to the Faculty of
Antioch University Seattle
Seattle, WA

In Partial Fulfillment
of the Requirements of the Degree
Doctor of Psychology

By
Kelley Simmons Jones

August 2014

Childhood Sexual Behavior:

An Integrated Developmental Ecological Assessment Approach

This dissertation, by Kelley Simmons Jones, has been approved by the Committee Members signed below who recommend that it be accepted by the faculty of Antioch University Seattle, in Seattle, WA in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

Dissertation Committee:

Mary Wieneke, Ph.D.
Chairperson

Melissa Kennedy, Ph.D.

William Luecke, Ph.D.

Date

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Abstract

Childhood Sexual Behavior:

An Integrated Developmental Ecological Assessment Approach

Kelley Simmons Jones

Antioch University Seattle

Seattle, WA

This qualitative, theoretical review and analysis of extant literature explored the sociocultural influences effecting conceptualization of childhood sexual behavior problems. Themes emerged from analysis of peer-reviewed journals that illustrated the complex, multidimensional, and ecological factors influencing child sexual development and problematic sexual behavior. These included major themes of Child Sexuality: Ecological Context, Developmental Context, Complex Trauma, and Ecological Interventions. Specific factors associated with childhood sexual behavior problems included trauma, domestic violence, sexual and physical abuse, psychological and emotional distress, impaired attachment, and the effects of diverse ecological systems such as the family, parents, and sociocultural influences of the greater community. Analysis culminated with an enhanced conceptualization of childhood sexual behavior named Ecological Developmental View. This conceptual model, integrated within the framework of ecological theory, evolved into an innovative approach of clinical assessment for childhood sexual behaviors applicable in outpatient clinical settings. The model, Integrated Developmental Ecological Assessment Approach (IDEAA), recognized the significance of the developing child influenced within the ecological contexts of the child, family, social, and community environments. The IDEAA model

intends to help professionals and adults to address concerns related to childhood sexual behavior from an ecological perspective that will enhance and benefit outcomes for children, parents, families, and communities. The electronic version of this dissertation is at OhioLink ETD Center, www.ohiolink.edu/etd

I dedicate this accomplishment to Scotty Jones, my wonder twin, for your extensive love and support, for your courage and compassion, your amazing sense of humor that keeps me laughing, and for walking with me on this life journey together.

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Introduction

There has been an insurgence of attention over almost thirty years from researchers and clinicians on the issue of child sexual behaviors, currently referred to as child sexual behavior problems. Behaviors exhibited by children labeled *sexual* typically involve genital parts often referred to as sexual parts. Some childhood sexual behavior and exploration is regarded as typical and normal while other sexual behaviors are considered concerning and developmentally inappropriate or *problematic*. According to the Association for Treatment of Sexual Abusers (ATSA), childhood sexual behavior problems do not represent a medical or psychological syndrome or specific diagnosable disorder; rather, these are a set of behaviors occurring outside the range of normal behaviors and acceptable societal norms (Chaffin et al., 2008).

Problematic sexual behavior as defined in the literature occurs frequently, with intensity, and may result in emotional or physical distress for the children involved (Chaffin, 2008; Chaffin et al., 2008). The most concerning child sexual behavior problems entail interpersonal behaviors with other children who are developmentally older, or who exhibit advanced sexual knowledge, aggression or coercion, injury, or the potential for harm (Chaffin, 2008; Johnson, 2002). Child sexual behavior problems range significantly in their degree of severity and harm. As stated in the ATSA report, “although some features are common, virtually no characteristics are universal and there is no profile or constellation of factors characterizing these children” (Chaffin et al., 2008, p. 200).

When children disclose, or an adult observes contact between two or more children involving genitals or intimate body parts, such as breasts or buttocks, they may react with alarm. Adults commonly identify these as sexual acts, interjecting sexual intent particularly when behaviors emulate mature sexual acts such as oral-genital contact or penetration of the vagina or anus. When children particularly those under age twelve, exhibit sexual behaviors interpreted as harmful, coercive, or aggressive, adult concerns and fears escalate (Chaffin et al., 2008; Finan, 1997; Heiman, Leiblum, Esquilin, & Pallitto, 1998; Kellogg, 2005). This results in significant distress among parents and caregivers, schools, childcare centers, doctors and therapists, including child protection agencies and law enforcement. This is particularly true when the behaviors involve another child, versus solitary sexual behaviors.

Fear and confusion heighten as involved adults struggle to differentiate normal versus maladaptive behaviors, as well as contributing factors and effects of the child's sexual behavior deemed intrusive and *problematic*. Complexity of this issue seems rooted in uncertainty and sociocultural beliefs related to childhood sexuality and sexual development.

There appears to be an absence of knowledge and modern understanding on child sexual development specific to children in 21st century United States. In particular, there is scant research on child sexuality that considers unique variables such as age, race, cognition, ethnicity, disability and other related developmental influences (Heiman et al., 1998; Thigpen, 2009). The absence of comprehensive guidelines for normal childhood sexual development and exploration seems filled by broad cultural values and beliefs that are socially constructed.

Sociocultural Response: Childhood Sexual Behavior

A sociocultural approach accentuates the co-occurrence and interdependence of social and individual processes that occur within varied environments, or cultures (John-Steiner & Mahn, 1996). Emphasis is on the cultural contexts where human activity occurs, best understood within historical development of the cultural context. Differences including beliefs, values, social expectations, and practices can exist in subcultures embedded within larger diverse cultures and systems (John-Steiner & Mahn, 1996).

Sexuality and childhood sexual development challenges many adults' perceptions of what it means to be a child. Contextual and cultural differences influence adult perceptions regarding child sexuality and what behaviors are considered normal or not, or reasoned problematic. There are biological and developmental theories that identify parameters of normal sexual development across stages of maturation; yet literature about children's sexual knowledge, experiences, and behaviors remains limited. Social, cultural, and familial contexts determine what is normal and acceptable; therefore, defining parameters of normal childhood sexual behavior is an ominous task.

Risks and concerns related to child sexual behaviors seem constructed by various influences that likely have changed over time and may no longer be accurate. Specifically in the United States, early studies suggested a strong association between child sexual abuse and child sexual behavior problems (Friedrich, Beilke, & Urquiza, 1987; Friedrich & Luecke, 1988; Gale, Thompson, Moran, & Sack, 1988; Johnson, 1988; 1993; Kendall-Tackett, Williams, & Finkelhor, 1993). Publications in the fields of social science and psychology suggested that 65-100% of children under age twelve exhibiting

sexual behaviors had been sexually victimized (D. L. Burton, Nesmith, & Badten, 1997; Friedrich, 1995b; Friedrich & Luecke, 1988; Gale et al., 1988; Gil & Johnson, 1993; Johnson, 1988). Childhood sexual behavior and symptoms diagnostic of post-traumatic stress disorder (PTSD) became the most reliable indicators of child sexual abuse (Kendall-Tackett et al., 1993).

Literature on pedophilia emerged early in 1980 that revealed various concepts related to the sexual motivations and actions of adult sexual offenders (Araji & Finkelhor, 1986; Cohen, 1981; Howells, 1981). Theories on sexual learning emerged which implied children developed sexual behavior through a process of mimicking suggesting that many sexually abused children would repeat their abuse in some manner later in life (Araji & Finkelhor, 1986; Cohen, 1981). Such theories suggested children learned sexual behaviors from personal or witnessed sexual experiences, and then emulated the victimization by shifting roles from victim to aggressor (Araji & Finkelhor, 1986; Cohen, 1981). This concept enhanced the belief and suspicion that a child's sexual behavior was indicative of sexual abuse; thus, a diagnostic pattern was set. Limited information allowed a precedent to emerge for how clinicians and others responded to children exhibiting sexual behaviors.

Fear and repercussions. As child sexual behavior problems became a more recognized area of interest and concern, labels and stereotypes emerged that carried stigma and repercussions. Children exhibiting sexual behaviors discerned as problematic were referred to as “child perpetrators,” “children who molest” or “sexually aggressive children” (Friedrich & Luecke, 1988; Gil, 1986; Johnson, 1988, 1993). A child exhibiting sexual behaviors, as young as 4-years-old, may be labeled as either a victim of

sexual abuse, as a sexually aggressive predator, or both (Chaffin, 2008; Chaffin et al., 2008). Labels such as perpetrator or offender, often utilized in the legal system with adolescents and adults, carry a negative fear-evoking stigma especially when applied to children. Although there have been modern revisions to these labels, “child sexual behavior problems” and “children with sexual behavior problems” (Chaffin et al., 2008; Kellogg, 2010; Letourneau, Schoenwald, & Sheidow, 2004; Swisher, Silovsky, Stuart, & Pierce, 2008), labels continue to be used and affect perceptions of the child.

Labels and stereotypes inadvertently heighten fear and concern among communities, stigmatize children, and set in motion a chain of reactions among adults. Fear based reactions may result in restricted access to other children and peers, ensuing social isolation and exclusion. School systems, social service agencies, and parents react by expelling children from schools, programs, and homes where other children reside. Based on years of professional experience, the threat of a civil law suit against the parent of the child exhibiting the sexual behaviors, or against the school or childcare center where the sexual touching occurred, is a reality.

Parental custody issues may exacerbate as divorced or separated parents blame, accuse, and suspect each other as responsible for the child’s behaviors. Fear based responses are particularly evident for children separated from parents and disrupted from foster, relative, and adoptive homes (Bonner, Walker, & Berliner, 1999; Chaffin et al., 2008; Tarren-Sweeney, 2008). Ultimately, adult responses to a child’s sexual behaviors results in multiple disruptions and additional trauma to the child (Chaffin et al., 2008).

The question of *who abused this child* often becomes the primary focus, rather than the evaluation of the behaviors in the context of their occurrence. When adults convey an overriding fear that the child may be sexually aggressive or a future sexual predator, the child may be traumatized by the reactions of adults (Chaffin 2008; Chaffin et al., 2008, Tarren-Sweeney, 2008). Questions of safety rise to the forefront for all children involved. Well-intentioned adults from varied disciplines such as law enforcement, child welfare services, medical and psychological services, educators and court systems, tend to respond to reports of child sexual behavior with alarm. When helpers view child sexual behavior through a lens of fear, as pathological and requiring *special* or punitive attention, then even well intended assistance for children and families can be overwhelming.

Yet, the origins of sexual behavior problems are not definitive, and most children exhibiting sexual behavior problems have no known history of sexual abuse (Bonner et al., 1999; Chaffin, 2008). Documented evidence indicates children engage in concerning and intrusive sexual behaviors based on a multiplicity of influences such as family dynamics and diverse environmental factors (Chaffin et al., 2008; Friedrich, 2007; Kellogg, 2010; Shaw, 2000). Consequently, conceptualizations of problematic child sexual behaviors need further clarification and expansion to include current research within the sociocultural and ecological context of the 21st century.

Professional Context: Role of the Researcher

The clinical expertise and background of this researcher is relevant to this study. My clinical experience began over 25 years ago with assessing, treating, and advocating for abused, maltreated children, youth, and families. In addition, I spent 15 years as a

clinical and medical social worker in a hospital-based sexual abuse and child maltreatment clinic. Experienced with the Developmental Therapy-Teaching (DTT) model (Wood, Davis, Swindle, & Quirk, 1996; Wood, Quirk, & Swindle, 2007), I was the first regionally certified DTT trainer in the State of Washington in 1999.

Additionally, I spent over 20 years collaborating with the state Department of Child and Family Services (DCFS) and as a community member on the Child Protection Team. I was the founding executive director of a state certified therapeutic child development program for children birth through six-years, at-risk for maltreatment and neglect, and their families involved with DCFS. These collective experiences contributed greatly to my knowledge and interest in child sexual behavior, sexual abuse, and child maltreatment as embedded within ecological systems, and their impact on children, families and our communities.

In terms of assistance and guidance, there has been too little to offer children with problematic sexual behaviors. For many years, I consistently witnessed caregivers, therapists, medical providers, DCFS social workers, and law enforcement repeatedly voice apprehensions about children exhibiting sexual behaviors that involved other children. My experience yielded frequent communications with alarmed adults who feared the child exhibiting sexual behaviors had been a victim of sexual abuse. Moreover, when the sexual behavior involved another child there was additional apprehension the exhibiting child was a prospective sex offender. These scenarios were quite complex and concerning. Often the reactions of the adults exacerbated the situation, resulting in outcomes that were vague and unresolved.

Children with sexual behavior concerns were often referred for a medical or forensic sexual assault evaluation instead of being referred for an assessment by a psychologist or clinical therapist. Most forensic sexual abuse evaluations, even with a verbal disclosure from a competent child, rarely reveal any physical evidence of sexual abuse (Adams, 2005; Bowen & Aldous, 1999; Heppenstall-Heger et al., 2003). Studies have shown that 85% - 95% of children who gave clear histories of sexual abuse had no physical findings of acute or healed trauma on examination (Adams, 2005; Berenson & Grady, 2002; Bowen & Aldous, 1999; Heppenstall-Heger et al., 2003).

Despite these findings, a child who exhibits sexual behaviors with no verbal disclosure of sexual abuse continue to be referred for a forensic medical evaluation. This seems predicated on the belief that childhood sexual behavior is indicative of sexual abuse, and often the community has little else to offer for assessment of a child presenting with sexual behavior concerns. Outcomes from medical or forensic sexual abuse evaluations are often deemed unclear, nonspecific, and unhelpful in addressing concerns specifically related to a child's sexual behavior.

In an effort to respond more effectively to the needs and concerns of the community, I went in pursuit of answers. I sought an alternative approach for assessment of childhood sexual behavior, other than a medical or forensic sexual abuse evaluation. My intention has been to identify, or develop, a conceptual model for assessing children exhibiting problematic sexual behaviors based upon contemporary research.

Clinical Assessment: Complexity of Childhood Sexual Behavior

Clinical assessments play a foundational role for informing treatment planning and guiding interventions for caregivers, schools, and other involved adults or

professionals. Additionally, when Child Protection Services (CPS) or child welfare social workers are involved, assessments help determine recommendations for the child and family and identify risk and safety issues that may inform child placement decisions.

Assessment and effective interventions for children exhibiting sexual behaviors present a challenge for psychologists, professionals, and communities. The task of identifying and locating an outpatient psychologist or clinician, confident and capable to assess a child exhibiting sexual behavior concerns can be daunting. The number of children referred for specialized treatment related to sexual behavior problems appears to have increased in recent years (Chaffin et al., 2008).

The complexity of problematic child sexual behavior may deter mental health and psychological clinicians from becoming involved. Professionals lacking comprehensive knowledge on this issue and a process for assessment may inadvertently react in an alarmed manner to a child's reported sexual behavior. They may avoid working with the presenting problem believing they must refer the parent and child to find a specialist. They may perceive the sexual behaviors as predatory, or possibly reactive to a child's sexual victimization based on the reported involvement of genital parts. The reality that clinicians assessing sexual behavior problems are simultaneously evaluating the possibility of sexual abuse or other forms of maltreatment convolutes this scenario. Both raise trepidation and concern regarding the protection and well-being of the child, family, and community.

Despite the relevant importance of clinical assessment, clear guidelines and specific assessment models utilized in outpatient clinical settings are difficult to find in the published literature. Many of the early-published curricula approached assessment of

child sexual behavior specifically in relation to child sexual abuse (Johnson, 1993, 1996, 1998; Johnson & Friend, 1995; MacFarlane & Cunningham, 2003). Identified assessment models and guidelines were components of treatment curriculum for sexual behavior problems or as part of a research study. The majority of the assessment models available in the literature had limited or no empirical support; many models focused on sexually abused children or adolescents, exhibiting sexual behavior problems (Johnson, 1993; Johnson, 1996, 1998; Johnson & Friend, 1995; MacFarlane & Cunningham, 2003; Offermann, Johnson, Johnson-Brooks, & Belcher, 2008; L. A. Rasmussen, 1999, 2004; L. A. Rasmussen, J. E. Burton, & Christopherson, 1992). Other assessment guidelines found were limited to the context of a research study, primarily for evaluating participants for inclusion in the study. Such information involved assessment instruments, components or resources neither intended nor validated for application in an outpatient clinical setting.

Contemporary practitioners and researchers in the field advocate the necessity for clinicians to employ a multidimensional, integrated framework for assessment of childhood sexual behaviors (Friedrich, 2007; Grant & Lundeberg, 2009; K. Rasmussen, 2006; L. A. Rasmussen, 2004). Recent literature recommended a comprehensive, developmentally appropriate, individualized assessment. Such an assessment would help identify risk factors of children exhibiting sexual behaviors, help create relevant individualized treatment plans and interventions, and assist parents and caregivers with appropriate support and adequate supervision (Chaffin et al., 2008; Friedrich, 2007; L. A. Rasmussen, 2004). Conceivably, hesitant clinicians would benefit from an updated conceptualization of child sexuality and problematic sexual behavior, along with a

conceptual framework for assessment of a behavioral problem rather than a sexual problem.

Significance of the Study

This non-experimental study provided the opportunity to step back and view concerns of childhood sexuality and children exhibiting problematic sexual behaviors from a new lens. This study sought to understand this concern through a comprehensive and thorough review and synthesis of varied empirical publications across almost thirty years. Understanding the origin and context of beliefs and opinions derived from historical and current research aids in modern-day comprehension of this issue. Moving forward towards a contemporary context, aids in preparing clinicians and psychologists to respond to these presenting concerns.

Accurate assessment of the issues related to children exhibiting sexual behaviors is indispensable for appropriate interventions for the child and family. Assessment from an ecological perspective accounting for the sociocultural and developmental context of the child and behaviors is essential to the improvement in understanding and treating issues of sexuality in children. Expanding awareness of childhood sexual behaviors could improve access to appropriate services and supports, while reducing stigma around a child's behaviors. Similarly, increasing access to an innovative assessment model could provide a mechanism to enhance outcomes for children, families, and communities.

Development of a conceptual assessment model required review, analysis, and synthesis of almost thirty years of theoretical, empirical, and clinical knowledge on the multidimensional factors affecting children exhibiting problematic sexual behaviors. Theoretical content reviewed and analyzed for this study derived from expert opinions,

understandings, and empirical research on childhood sexuality and sexual behavior problems specific to the United States of America, with a few studies that involved partnerships with Canadian researchers. Creation of an innovative assessment model for childhood sexual behaviors applicable in outpatient clinical settings has utility and benefit for clinicians, and provides a valuable contribution to the field of clinical psychology.

Language and Definitions

Language is a relevant component of sociocultural interpretations. The terminology and labels construct opinion and beliefs that often unknowingly perpetuate stereotypes. Previously noted, language and labels applied to children exhibiting behaviors construed as sexual and problematic, impact beliefs about the child and their behavior. Therefore, terminology applied in this study was crafted to reduce assumptions and motivations about a child and their behavior.

Specifically this study relates to preadolescent children who have not reached sexual maturation. This distinction made differentiates the developmental age/stage of childhood from adolescent development. Thus, the terms *child*, *youth*, *juvenile* or *children* in this study refers to children who are twelve years of age or younger.

The term *childhood sexual behavior* identifies behaviors exhibited by a child that may or may not occur within a typical developmental stage for the child. The behavior itself may reflect sexual development or sexuality of a child, and may not be problematic. Additionally, even though behavior labeled as sexual due to involvement of genital or intimate parts of the body or evidence of mature sexual knowledge, such behavior may not involve sexual intent, arousal, or sexual gratification. Use of the phrase childhood

sexual behavior intends to support the reader's conceptualization of a child's behavior through an objective lens rather than frame behavior with loaded terminology that immediately implies pathology, or that the behavior is problematic or predatory.

Child sexual behavior problems (CSBP) is a term applied widely in published literature since the late 1990s (Araji, 1997; Bonner et al., 1999; Chaffin & Bonner, 1998; Friedrich & Trane, 2002; Hall, Mathews, & Pearce, 2002; Pithers, Gray, Busconi, & Houchens, 1998). This term refers to children younger than 12-years-old who exhibit sexual behavior identified as problematic. CSBP as defined in modern literature (a) occurs at a greater frequency or at a much earlier age than would be developmentally expected, (b) interferes with their development, (c) can involve coercion, intimidation, or force, (d) is associated with emotional distress for the children involved, and (e) reoccurs secretly even after caregiver intervention (Silovsky & Niec, 2002).

Ecological Systems Theory (1977, 1979, 1989, 1994): designed by developmental psychologist, Urie Bronfenbrenner, emphasizes that several environmental systems (i.e. microsystem, mesosystem, exosystem, macrosystem, and chronosystem) play a major role in human development. Specifically that human development evolves from the person, the environment, and the continuous interaction of both.

Ecological Model: Jay Belsky (1980, 1993) applied Urie Bronfenbrenner's ecological model of human development to child maltreatment. This integrated, ecological model proposed that the child and parent, biological and psychological characteristics, along with numerous sociocultural and environmental factors, were interrelated to influence child maltreatment.

Sociocultural system is a term that describes individuals viewed within an ecological context, embedded within subsystems of a greater ecological system (Nanda, 1984). Sociocultural theory in relation to human development implies that cognitive developmental processes, learning processes, and psychological processes are products of systems of an individual's society and culture (John-Stiener & Mahn, 1996; Tudge & Scrimsher, 2003). Society exists as an aspect of culture comprised of the interaction of beliefs, values, manners, normative behaviors, and practices of a particular social group. Socialization within a specific culture and society molds behavior and reinforces broader cultural values or standards of what constitutes the norm (Clausen, 1968). As related to children, development occurs within cultural contexts, mediated by language and other systems, and is best understood when examined within their sociocultural context (John-Stiener & Mahn, 1996).

Transactional Model developed by Cicchetti and Rizley (1981), expanded the ecological model of child maltreatment. They noted that within the ecological model, there were various interactions, or transactions, that occurred between various factors referred to as either *potentiating* (risk or debilitating) or *compensatory* (protective) *factors*.

Typology is a classification system intended to differentiate subtypes of a specified population, based on definitional criteria. Several practitioners have developed typologies describing subtypes of children and adolescents who engage in sexualized and sexually abusive behaviors. Many of these typologies were formulated intuitively through clinical practice experience; others are empirically derived.

Association for the Treatment of Sexual Abusers (ATSA) Task Force has an overall mission of promoting current, effective interventions and practices specific for individuals who engage in sexual behavior considered abusive. The Task Force on Children with Sexual Behavior Problems was responsible to produce a report specifically to guide and inform professional practices with children, ages 12 and younger. Members of the ATSA Task Force were Mark Chaffin, Lucy Berliner, Richard Block, Toni Cavanaugh Johnson, William N. Friedrich, Diana Garza Louis, Tomas D. Lyon, Jacqueline Page, David Prescott, Jane F. Silovsky, and Christi Madden.

Methodology

This chapter identifies connections between the epistemology and specific research type utilized in this study. Comprehending outcomes of research contributions depends entirely upon understanding the research paradigm, methodological approach, and research design of a study. A paradigm is an interpretative structure steered by a system of beliefs and feelings about the world, comprehended, and studied, which guide the researcher in various ways (Guba & Lincoln, 1994). A research paradigm is the framework for the study of inquiry that encompasses the philosophical assumptions, research approach, and type of inquiry for the study.

This non-experimental research is a theoretical conceptual dissertation. Dissertations with a theoretical framework typically involve the review, analysis, and synthesis of current theories and varied definitions of concepts within a particular discipline. A conceptual framework identifies relevant patterns and makes explicit proposed connections between the points of inquiry and the data. Consistent with qualitative research, an innovative theory or concept often emerges as an outcome of analysis in theoretical and conceptual research.

Theoretical and conceptual dissertations are similar, yet there is no apparent unified agreement as to what constitutes the research design for a conceptual or theoretical study. Differentiating what they are and how to prepare them can vary. Prior to constructing the design for this theoretical-conceptual study, a thorough review of multiple methods of qualitative research and analysis was completed.

A theoretical study entails a thorough review of data consisting of previously published literature, along with the incorporation and integration of varied findings and

beliefs, which culminate in development of an original concept, new integrated theory, or innovative model regarding some aspect of clinical practice (Antioch University Seattle, 2012; Institute for the Psychological Sciences, 2012; Wheaton College, 2011). Similarly, a conceptual study derives results from the synthesis of data or theories linked from research or literature to establish evidence in support of a novel concept. If there was valid research already linked to the concepts, then the model or framework is theoretical rather than conceptual.

This study combines aspects of theoretical and conceptual research that culminated with a new paradigm and an assessment model. Future research on the conceptual assessment model is necessary to establish valid and reliable outcomes and to demonstrate the effectiveness and utility of the proposed assessment model. Relevant core aspects of the model originated from extant information available in the published literature. The comprehensive literature search for this study included electronic databases, peer-reviewed professional journals, books, and other relevant sources found across diverse disciplines such as child development, nursing, pediatrics, psychology, and social work. Results from the content analysis integrated and informed the conceptual design of the assessment model.

Points of Inquiry

The methodology used in this study was selected because it supported the points of inquiry as well as limitations of time, resources, and experience of this researcher. The following points of inquiry were addressed within the sociocultural context of the United States of America. The aim of the study was to understand why and how childhood sexual behaviors pose concern, and inform others on ways to react and actions to take.

The key points of inquiry points for this study are as follows:

- How has clinical research and literature contributed to conceptualization of child sexual behavior problems in the United States of America?
- How is typical and *normal* childhood sexual behavior differentiated from maladaptive and *problematic* sexual behavior among children?
- How have sociocultural beliefs influenced comprehension and reactions related to childhood sexuality and sexual behavior problems?
- What are the related factors contributing to etiology and endurance of problematic childhood sexual behaviors understood within contemporary society?
- How does an empirical foundation inform the theoretical background for an innovative conceptual assessment model?

Epistemology: Social Constructivism

Epistemology is the core philosophical assumption, or stance, of a study or research inquiry. Philosophical assumptions represent beliefs and conjecture used to interpret experiences and make meaning. Epistemology, referred to as "theory of knowledge," questions what knowledge is and how it can be acquired, and the extent to which any given subject or entity can be known (Creswell, 2003; Onwuegbuzie, Leech, & Collins, 2012). This stance guided this researcher to particular ways in which to examine the particular phenomena. It provided a framework for seeing, observing, and interpreting throughout the process of inquiry.

Two major philosophical doctrines of inquiry are positivism and post-positivism. Positivism, associated with traditional scientific inquiry, assumes that physical and social

reality is independent of those who observe it. Observation of this *reality*, if unbiased, constitutes scientific knowledge (Dills & Romiszowski, 1997). Quantitative research follows a positivist paradigm closely aligned with objective measures and research designs. Generally, the quantitative researcher relies upon numerical verification of observations to support their predictions (Suter, 2012). Theory provides an explanation for the prediction or hypothesis in a study rather than emerging from the study. In contrast, post-positivist or constructivist philosophy relies on the belief that those who participate within it *construct* reality. Individuals build their own understandings of the world through experience, across time and maturation (Dills & Romiszowski, 1997). This constructivist assumption underpins the significance and rationale for this study.

Many subjective influences and experiences composed this researcher's epistemological assumption. Construction of reality results from personal, social, historical, and cultural experiences, and the meanings attached to and derived from those experiences. These assumptions formed my biases and values, the lens through which I perceived and interpreted meaning. These views supported all aspects of my inquiry and approach to this study. I understood that I am not separate from the research process; rather I am a component of the research. I openly acknowledged my role collaborating in the research (axiology). My biases and values interwoven throughout the process of inquiry were not separate from the research process or conclusions.

Constructivist research acknowledges the multiplicity of subjective awareness and appreciates the variety of different constructions of meaning that people make from their experiences (Alvesson & Skoldberg, 2009). As applied to research inquiry, meaning derives from the perspectives of those who engage the experience and construct its

meaning. The social constructivist researcher looks for greater complexity and broadening of understanding rather than narrowing (Creswell, 2003; Suter, 2012). The rhetorical assumption in this study was the writing needed to be personal and literary in form, compared with traditional quantitative terms, numerical results, and scientific language. Throughout this dissertation, a constructivist epistemology acknowledged my interpretation of the sociocultural context, contributing factors, and experiences as related to childhood sexual behaviors.

The sociocultural aspect of research involves the delineation and justification of how the research situates in society; as well as whose interests are represented and what contribution, or effect on society may occur as a result (Onwuegbuzie, Johnson, & Collins, 2010). The objective of this study was the systematic review, analysis, and synthesis of scientific knowledge and understanding of the continuum of childhood sexual behaviors, those considered typical and problematic. The intent was greater comprehension of this presenting problem through research synthesis and analysis of peer-reviewed literature. The social and cultural context of each author's conclusions and expert opinions expressed in the clinical and empirical literature had significance.

In order to create a current and innovative method of assessment for children with sexual behavior concerns, knowledge and cultural beliefs needed synthesized to reflect a comprehensive understanding of this concern in the context of social culture in the United States. Such a model would offer clinicians a mechanism to address the needs of children and families presenting with sexual behavior concerns, while also expanding comprehensive understanding on this topic in the field of psychology and social science.

Research Approach: Explanatory

Methodology identifies an appropriate approach for the research objective that includes the overall design and methods of inquiry. It offers the rationale for understanding which method, or set of guidelines, is most applicable to a specific study. The theoretical rationale positioned early in the research becomes an organizing model for the research questions and data collection procedure. The type of inquiry related to the epistemological assumption of the research guides the approach, design, and methods of the study.

Quantitative research reflects a positivist epistemology wherein deductive reasoning provides the type of inquiry for the study. A positivist approach utilizes deductive reasoning with the intention of testing or verifying a theoretical prediction rather than developing one. In quantitative studies, the intent is to “narrow down” or deduce a collection of observations and results to prove or disprove the hypothesis. Data collected, such as information obtained from participants, is typically in numerical form.

Post-positivist research, viewed through a constructivist lens, favors a philosophical orientation of interpretivism as an inductive process. Inductive reasoning refers to the process of discovering patterns, themes, or categories identified from specific examples in the data. Thus an inductive approach to research, “bottom-up” logic, transpires as conclusions emerge from the data from a specific to a more general theory or novel explanation, rather than data used to verify the theory or prediction (Creswell, 2007, 2008; Suter, 2012). Qualitative exploration of data is flexible in the sense that the researcher is open to new constructs, ideas, and explanations or theories throughout the process. Inductive procedures involve the researcher as an instrument,

relying on the researcher's skills to receive information and to uncover its meaning by descriptive, exploratory, or explanatory conceptual procedures (Creswell, 2007, 2008; Suter, 2012). Some qualitative studies include both deductive and inductive reasoning in the research approach.

The analytic approach for this study was explanatory, or conceptual, analysis. This approach to research is traditionally associated with quantitative studies often testing hypothesis by measuring relationships between variables and statistical methods of analysis. However, it is also an applicable approach to qualitative research combining deductive and inductive methods (Guest, MacQueen, & Namey, 2012). An explanatory approach often occurs when a hypothesis already exists as to why something occurs and intends to explain rather than describe the phenomenon of study. An explanatory approach is one of deconstructing the concept from existing literature and developing a conceptual framework in relation to the inquiry. Previous work becomes the scaffold for further exploration on the internal dynamics of the original concept of inquiry (2011). Explanatory analysis results in a conceptual framework for identifying new sources of data for collection and analysis, providing further response to the inquiry from a different perspective. This approach offers the potential for new knowledge by creating a model or theory that can be further tested and explored. For this study, an explanatory approach to qualitative analysis was appropriate and fit well with my philosophical assumption of constructivism.

Research Type: Qualitative

Qualitative research is an inquiry process of understanding that explores a social or human issue or problem. The researcher analyzes words and detailed information and builds a complex, holistic picture often conducted in a natural setting (Creswell, 2008; Merriam, 2009). The qualitative method investigates *why* and *how* questions, not just what, where, and when.

There appears to be great variation in the way writers describe the philosophical aspects of qualitative research (Merriam, 2009; Suter, 2012). Diverse theories of inquiry exist across many fields of study including the social science disciplines of psychology, sociology, anthropology, education, and economics (Creswell, 2008). Ultimately, the qualitative researcher makes sense of the content in a personal and socially constructed manner. Qualitative researchers use terms such as “patterns” and “theoretical lens” to describe theories or broader explanations in their studies, along with the discovery and design of innovative concepts, theories, or models (Creswell, 2008; Suter, 2012). Conclusions typically derive from recognized patterns and exposed concepts, not statistical relationships. Completion of the analysis occurs as a novel configuration eventually forms, held tight by the interconnected pieces. An innovative model or theory emerges in response to the points of inquiry and explains the phenomenon of interest (Miles & Huberman, 1994).

Variations in quantitative and qualitative research design, philosophy, research approach, and methods, have much to offer scientific inquiry across diverse fields of study with many shared components and similar terms. They value rigorous data collection and analysis linked to a strong chain of evidence, resulting in clear arguments

that describe scientific reasoning and sound conclusions. A good qualitative study, demonstrates a logical chain of reasoning and multiple sources of converging evidence to support an explanation or innovation (Richards, 2005; Suter, 2012). Qualitative analysis relies upon diverse researcher skills, techniques, and procedures depending upon the type of analysis selected. Coding skills and procedures are essential for sound research and to avoid feeling lost in a large volume of data (Richards, 2005). Capturing the researcher's thoughts and influences, throughout analysis, is another aspect of the qualitative research process.

The intention of the qualitative analyst is to create shared meaning and understanding that forms a coherent structure, or a unified whole. The discovery of connections in the data may support a theory, revise one, or generate a new one. Curiosity and openness to multiple potentials supports this process of discovery. Engaging in "mental excursions," "side-tracking" or "zigzagging," while changing patterns of thinking, making linkages between the "seemingly unconnected," and "playing at it," all intend to "open the world to us in some way" (Patton, 2002, p. 544). Analysis culminates with synthesis of the data through the integration, conceptualization, and summarization of findings. Once a reasonable conclusion emerges, a visual representation of the conclusion provides a valuable description of the meaning of the data while conveying understanding to others. A visual model may portray a hierarchy or perhaps a causal chain, depicting the interconnections of constructs, limited only by the imagination of the researcher (Creswell, 2008; Richards, 2005).

This researcher sought to understand the ecological and comprehensive aspects of childhood sexual behavior. Rather than design a study collecting primary data from

participant interviews or surveys, the aim of this study was deconstruction and analysis of secondary content data from peer-reviewed journals as related to the topic of inquiry.

Published literature was a relevant source of qualitative data. It offered a comprehensive understanding, sociocultural and historical context of existing information and opinions about childhood sexual behavior. The literature also illustrated the perceptions and information that changed over time. The synthesis and integration of the data was necessary to formulate a conceptual approach to assessment for children that addressed this concern from a broad, ecological context.

Design and Method of Analysis

This chapter explains the link between my research design and methods. The research design for this study applied the format of a comprehensive literature review "consider(ed) as a methodological process in its own right" (Onwuegbuzie et al., 2012, p. 2). The value and purpose of an extensive, comprehensive literature review is not to be underestimated. According to Boote and Beile (2005), "a thorough, sophisticated literature review, is the foundation and inspiration for substantial, useful research" (p.3) and aims to help the investigator glean ideas, examine questions, and review the results of similar and related studies. A comprehensive review of the literature is a complex process that involves interpretation, summarization, analysis, evaluation, and synthesis of the research documents (Onwuegbuzie et al., 2010). Analysis breaks down the whole into parts or chunks in order to gain a greater understanding of the whole (Schwandt, 2007).

Research Design: Comprehensive Literature Review

Various critical and interpretive steps for conducting a comprehensive literature review, more aptly called a *research synthesis*, have been provided over the past decade (Onwuegbuzie et al., 2012; Dellinger & Leech, 2007; Fink, 2005). There are various benefits of conducting a thorough review of the literature. These include gaining knowledge of what has been examined or needs further examination, identifying relationships between theory and practice, discovering variables relevant to the topic, distinguishing research methods and designs, noting contradictions and limitations of studies, avoiding unnecessary replication, and identifying strengths and weaknesses of various approaches to research (Onwuegbuzie et al., 2012).

Generally, a comprehensive literature review follows seven basic tasks. These tasks include: 1) identify topic and points of inquiry, 2) sources chosen from databases and publications, 3) identify keywords and search terms, 4) screen criteria for inclusion and exclusion of selected sources, 5) apply the screening criteria, 6) conduct the review, and 7) illustrate the results (Fink, 2005; Fraenkel & Wallen, 2006). Although there is consistency in the structure of a literature review, there are various techniques for the analysis particularly because each selected literature source may include data that is qualitative, quantitative, or mixed methods research. Each selected article or literature offers a rich source of qualitative data for analysis. Potential sources of qualitative data within each selected source article may include the literature review of the article, the conceptual framework, the author's interpretation, discussion, and conclusion. Selection of the type of analysis applied in comprehensive literature review depends on the topic of inquiry and purpose of the review.

This research design applied an adapted and expanded framework of a comprehensive literature review. This study incorporated specific qualitative research components (abstract, analysis, and synthesis) within the framework of a literature review design. To abstract, refers to a process that helps reduce and factor out, or sort through, details that focus on a particular construct or idea, such as coding and categorizing details or themes from data in the literature. Analysis refers to the interpretative process, while synthesis is the composition of parts into a meaningful whole that is something new. Figure 1 illustrates the tasks of qualitative analysis for this study embedded within the structure of a comprehensive literature review.

Specifically the design for this study included two levels of review, a preliminary and secondary review, of selected literature qualitatively analyzed for the construction of something new. The preliminary literature review was necessary to gain a comprehensive understanding, across time, and broad range of familiarity on the points of inquiry related to children with sexual behaviors and problems. Familiarity on the topic was an essential aspect of qualitative analysis and was vital for this study. The points of inquiry in this study necessitated analysis and incorporation of the cultural context and construction of beliefs related to children exhibiting sexual behaviors.

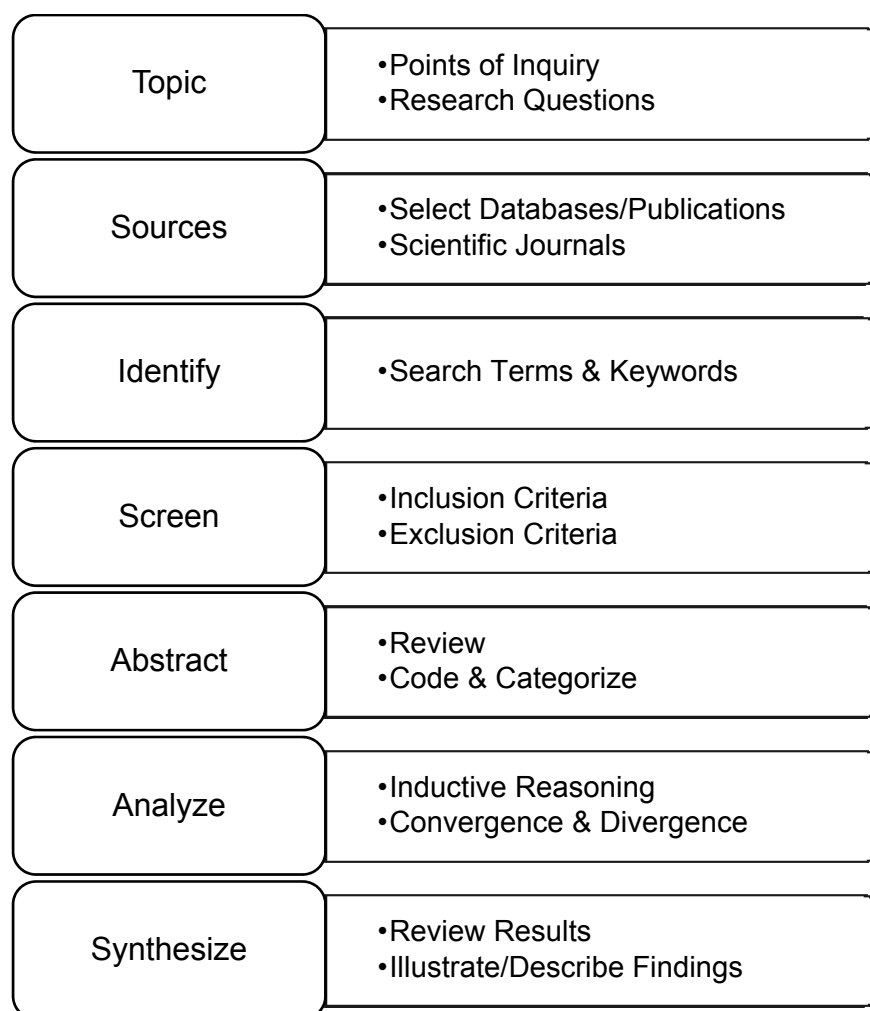


Figure 1. Qualitative analysis: Comprehensive literature review.

Understanding the historical context of this issue was an important element when discerning current knowledge and perspectives on childhood sexual behavior and problems. There was direct value in the analysis of the narrative thoughts of researchers and clinicians who studied children and sexual behaviors both past and present. Familiarity on this topic provided the researcher with context for the qualitative analysis. It also helped the development of exclusion and inclusion criteria for selection of source articles, secondary data, applied in the secondary literature review process.

Qualitative Methods

Qualitative research methods are diverse and summon many modes of thought, while applying creative approaches in research. Regardless of the epistemological, methodological, or sociological beliefs incorporated in a specific study of inquiry, there is an essential need for a clear and transparent detailed method, or process of inquiry. Detailed methods help ensure optimal outcomes and understanding of knowledge gained from the research process.

Research methods are the guidelines, specific strategies, and approaches, for conducting an actual study. Methods are the specific tools and techniques applied to the procedure of the study. Various mechanisms pertain to qualitative methods of analysis. These typically include procedures for data collection, analysis, interpretation, and reporting of data. These general processes tend to support all activities of qualitative data analysis. A qualitative procedure of data collection and analysis involves a simultaneous, collaborative process whereby ongoing findings influence the types of data collected and how they are collected (Merriam, 2009; Suter, 2012). At times, questions may evolve from the analysis that lead in new directions, sometimes answerable from the same data

source and other times not. This iterative process, involves a repeated movement back and forth throughout and between the content data. Other methods like convergence, the process of figuring out what things fit together to reveal patterns from the data, and divergence, examining content and building on information already known, apply in the analytic process. This analytic process of unveiling regularities or patterns among categories is the most common process in qualitative research known as thematic analysis (Suter, 2012).

Thematic analysis. Thematic Analysis is a qualitative method applicable for the unique analysis of secondary data, treating each selected work as an individual case. It is a systematic method to identify, analyze, and report patterns from within data and synthesize emerging thematic components into a novel design or concept. Thematic analysis is a foundational method for qualitative analysis. A benefit of thematic analysis is the flexibility in the exploration of data, allowing the researcher to remain open to new constructs and theoretical explanations throughout the analytic process. Although thematic analysis is widely applied in qualitative studies, there are diverse perspectives on what constitutes this as a method of analysis.

Variations such as discourse analysis, content analysis, and grounded theory may all fit beneath the overarching classification of thematic analysis. However, despite similarities they are viewed as distinctly different methods from thematic analysis. Braun and Clarke (2006) differentiate thematic analysis from other similar methods due to the method's flexibility and the absence of rigid technical or theoretical knowledge, as seen for example in grounded theory or discourse analysis. Thematic analysis has its own prescribed components and procedures worthy of application by researchers (Braun &

Clarke, 2006; Guest et al., 2012). Braun and Clarke (2006) denote a six-phased process for applying thematic analysis in psychology research. These phases include: 1) become familiar with the data; 2) generate initial codes; 3) search for themes; 4) review themes; 5) define and name themes; and 6) produce the report. Details of this six-phase process are highlighted later in this chapter.

In general, the task of the researcher is to become familiar with the textual content, abstract data, and identify a limited number of themes that sufficiently reflect the content. Review of the data during thematic analysis ensues as patterns and meanings are noticed in relation to the points of inquiry in the study; this may occur during data collection. A process of capturing data transpires through a technique of coding that occurs throughout analysis of the text (Howitt & Cramer, 2011). Analytic coding techniques and procedures take many forms, such as handwritten note cards or post-its, drafting memos in the form of notes, symbols, phrases, or sketches, a copy/paste or highlighter function in Microsoft Word, or a computer derived software program specifically for qualitative analysis such as NVivo, Atlas-Ti, or Dedoose. Coding skills and procedures reduce data into manageable, meaningful chunks to form categories and connections that link to emerging themes and concepts.

Coding in analysis begins with a broad review of the content creating memos and preliminary codes. This process continues until there is a sense of saturation that emerges from the source article's content. During the early phase of data extraction there is a constant process of moving between the entire data set, the coded extracts, and the thematic analysis that is emerging throughout the process (Braun & Clarke, 2006). Each level of analysis, from codes to themes, reaches higher levels of abstraction (Richards,

2005; Suter, 2012). Upon completion of analysis of the data, codes are combined into themes. Themes represent something significant captured about the data in relation to the points of inquiry; denoting some level of patterned response or meaning reflected within the data set (Braun & Clarke, 2006). Themes are illustrated and described in relation to the points of inquiry. Ultimately, narrative or graphic illustrations embody each integrated theme, representing the response or conclusion to the research inquiry.

Secondary data. Qualitative data analysis techniques lend themselves well to examining literature as a form of secondary data. Secondary data may come from diverse sources such as archival records, quantitative data sets, government-funded datasets, journal supplements, publications, and qualitative narrative transcripts. Secondary data analysis refers to analysis of data previously collected and examined by someone else, to answer questions that differ from the research questions for which the data were originally collected (Hinds, Vogel, & Clarke-Steffen, 1997). Advantages to using secondary data may include less cost, less time, and access to data related to sensitive populations or topics.

Literature as secondary data undergoes individual review for inclusion or exclusion in a data set. Thematic analysis is applicable with secondary data treating each selected source as an individual case or data set (Guest et al., 2012). Thus, each publication functions as a single unit containing various elements of relevant data for analysis within the context of the individual source article. In a stringent and sound manner each selected source article is reviewed, sorted, categorized, and analyzed (Onwuegbuzie et al., 2010, 2012). Regardless of the theoretical design of the original peer-reviewed article, the narrative components of the selected work contains numerous

sources of qualitative data for analysis. These might include the literature review, the author's discussion, and the author's interpretations (Onwuegbuzie et al., 2010, 2012).

Various steps were applied to the selection, review, and analysis of secondary data as the content in this study. The secondary data collected for this study was in the form of selected source articles from peer-reviewed journals. Within each selected source article, components such as the author's interpretations, discussion, and conclusions were qualitatively analyzed. Data collection for analysis was chosen through a secondary literature selection process that followed the preliminary literature review. Secondary data chosen for this study provided a rich source of qualitative data ripe for analysis.

Procedure

This study incorporated the research design of a comprehensive literature review with thematic analysis of secondary data that was specific narrative components of selected peer reviewed journal articles. Details follow on the process for both literature review searches and the procedures for the study.

Preliminary Literature Selection

This study examined knowledge and understanding on the subject of child sexual behavior from extant literature. It was essential to review the context of varied clinical and scientific opinions on this subject across time, in order to comprehend the ecological context and current perspective on the topic. The notion of ecological data is based on the concepts of culture and context. Thus, published studies convey knowledge and information that reflects the culture and context of the time-period when participants were subjects, as well as the professional opinions of the researcher/author portrayed through the rhetoric of their report.

Publications in the preliminary literature review search were included according to five criteria: a) topic: child sexual behavior concerns or problems, b) subjects: children and youth; c) language: English only; d) published: prior to January 2012; and e) sources: electronic databases, gray literature, and literature references. Sources searched electronically combined the terms "child," "children," "youth," "childhood," "sexual behavior," "sexualized behavior," "problems," "sexually aggressive," "assessment," "treatment," and "guidelines." Literature sources included psychological, social science, medical and health related electronic databases, publications, and gray literature sources, as well as dissertations, treatment manuals, books, conference presentations, and internet

websites like the National Child Traumatic Stress Network (NCTSN), National Center on Sexual Behavior of Youth (NCSBY) and Association for the Treatment of Sexual Abusers. One hundred and twenty-five (125) sources and publications available to this researcher met inclusion criteria. Titles and abstracts were screened to determine their potential relevance to the study. In addition, reference lists and bibliographies of selected sources were screened for additional relevant publications. Literature that did not meet criteria were excluded at this stage. The complete text of potentially relevant literature was examined. Figure 2 illustrates the process for selection of literature for the preliminary literature review process, which provided the foundation for this study.

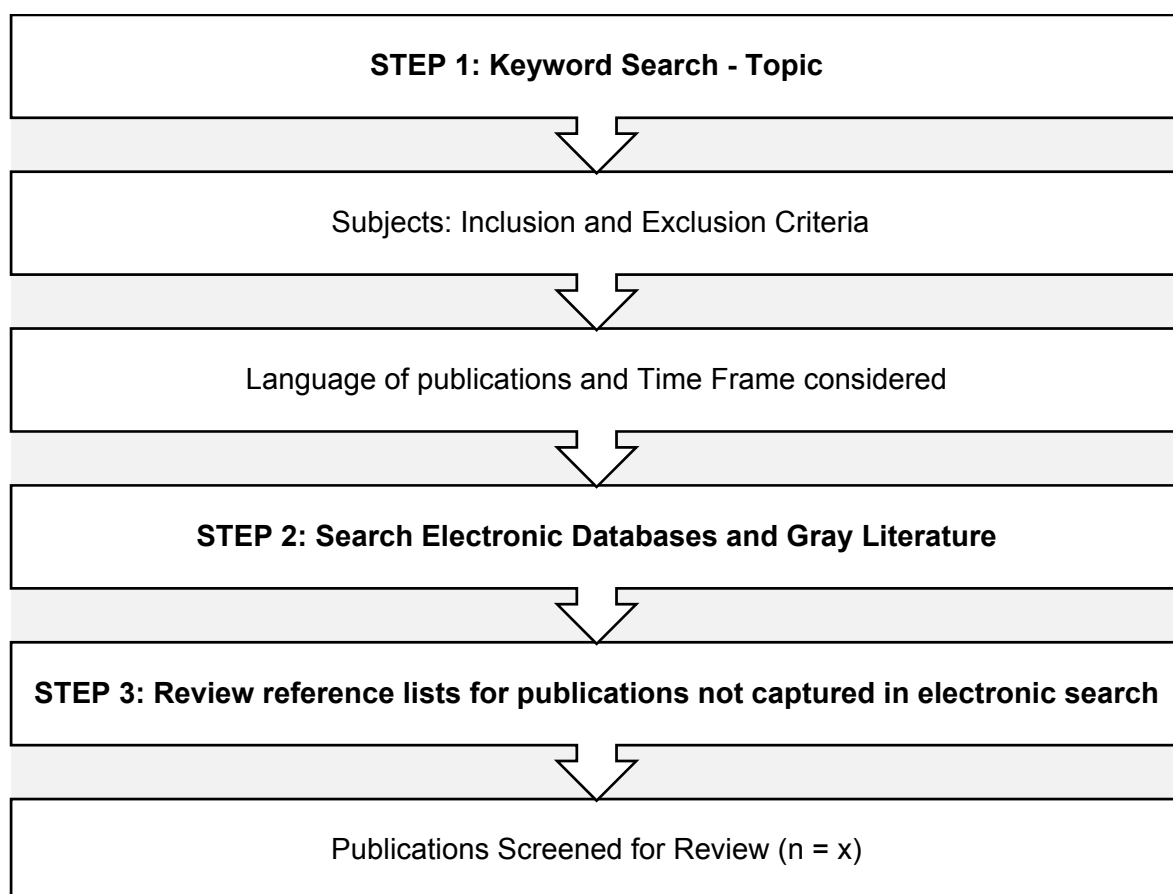


Figure 2. Process for selection of publications for preliminary literature review.

The preliminary literature overview provided the cultural context and comprehensive understanding of childhood sexual behaviors and problems that supported the identified need for an innovative conceptual model of assessment for children. Each article selected for the preliminary literature review underwent theoretical examination for relevance to the points of inquiry in the study. Engagement with the published literature prior to examination potentially narrows one's view of the analysis process; however, in contrast there is significant value for such familiarity that may enhance the analytic process due to the attention paid to more subtle aspects of the data (Tuckett, 2005, as cited in Braun & Clarke, 2006). Familiarity was necessary and beneficial as a component of this study. Following review of all the preliminary literature a comprehensive synthesis of selected content was completed, and comprised the history and background chapter of this theoretical study.

Preliminary Literature Review

The preliminary literature search encompassed literature and text from 1985-2012 from databases such as Ohio Link, ProQuest, PubMed, OVID, ERIC, PsycINFO, and Google Search. Publication reference lists were also screened for article inclusion. It appeared there was a paucity of research specific to assessment models and guidelines for preadolescent children, under age twelve, with sexual behavior concerns or problems (n = 4). The majority of publications available to this researcher focused on the following: assessment for adolescents charged with sexual offense, addressed descriptive characteristics and etiology of children with sexual behavior problems, identified sexual behavior solely in context of child sexual abuse, or were specific treatment programs for children and adolescents.

Diverse publications from almost thirty years reflected the cultural and ecological context of childhood sexual behavior and sexual behavior problems. As well as illustrating a continued expansion of knowledge and understanding on the etiology, characteristics, and interventions related to child sexual behavior problems. Various studies and expert opinions on childhood sexual behavior were selected for the preliminary and historical literature review on this topic. Figure 3 illustrates results of the preliminary literature review search. Results from the preliminary review influenced the designation of selection criteria for the secondary data collection process.

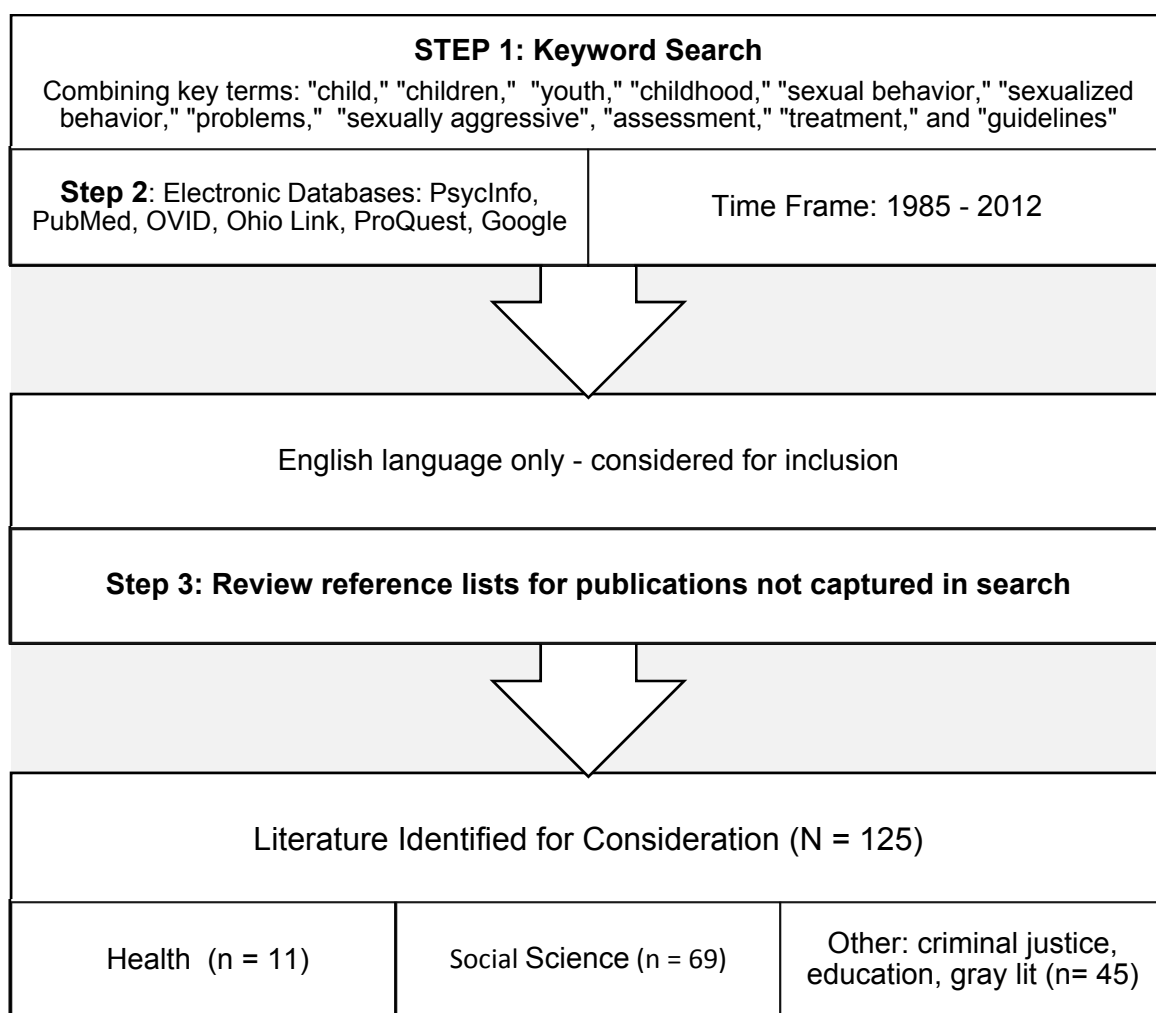


Figure 3. Preliminary literature selection search results.

Secondary Data Collection

The procedure for secondary data selection mimicked the process used for the preliminary literature review search. Results from the preliminary literature review were considered when creating parameters for the secondary data collection process. The qualitative researcher relies on their own skills to receive information, analyze, and uncover meanings from the data. In this study, due to the risk of experimenter bias, which occurs when data is inadvertently selectively chosen or documented as support for the researcher's hypothesis or interpretation, pre-established inclusion and exclusion criteria were defined and then applied during the secondary data collection process. Application of inclusion and exclusion criteria helped reduce experimenter bias by adding filters in the selection process.

Criteria were established congruent with the epistemology, design, and points of inquiry for the study. It appeared the onset of many publications on child sexual behavior and problematic sexual behavior appeared in the early 1980s and often focused on sexually abused children. Before the late 1990s, sexual behavior among children was less frequently identified as a concern for non-sexually abused children. Early publications about children and youth often focused on those older than twelve, termed adolescents or juveniles. Many studies included a range of ages through adolescence, blending children and teenagers. A larger body of literature specifically related to preadolescent children began to emerge at the turn of the 21st century.

Based upon a review of accessible publications on child sexual behaviors, non-specific to child sexual abuse, the designated period for secondary data collection was 1995-2012. A flow chart of the secondary data collection process, along with the

exclusion criteria, is illustrated in Figure 4. Source article selection was limited to peer reviewed publications only, originating within the United States of America and written in the English language. Investigators and authors were individuals and/or teams from within the United States that might include partnerships with non-US individuals or agencies, yet the research conducted included subjects from the United States.

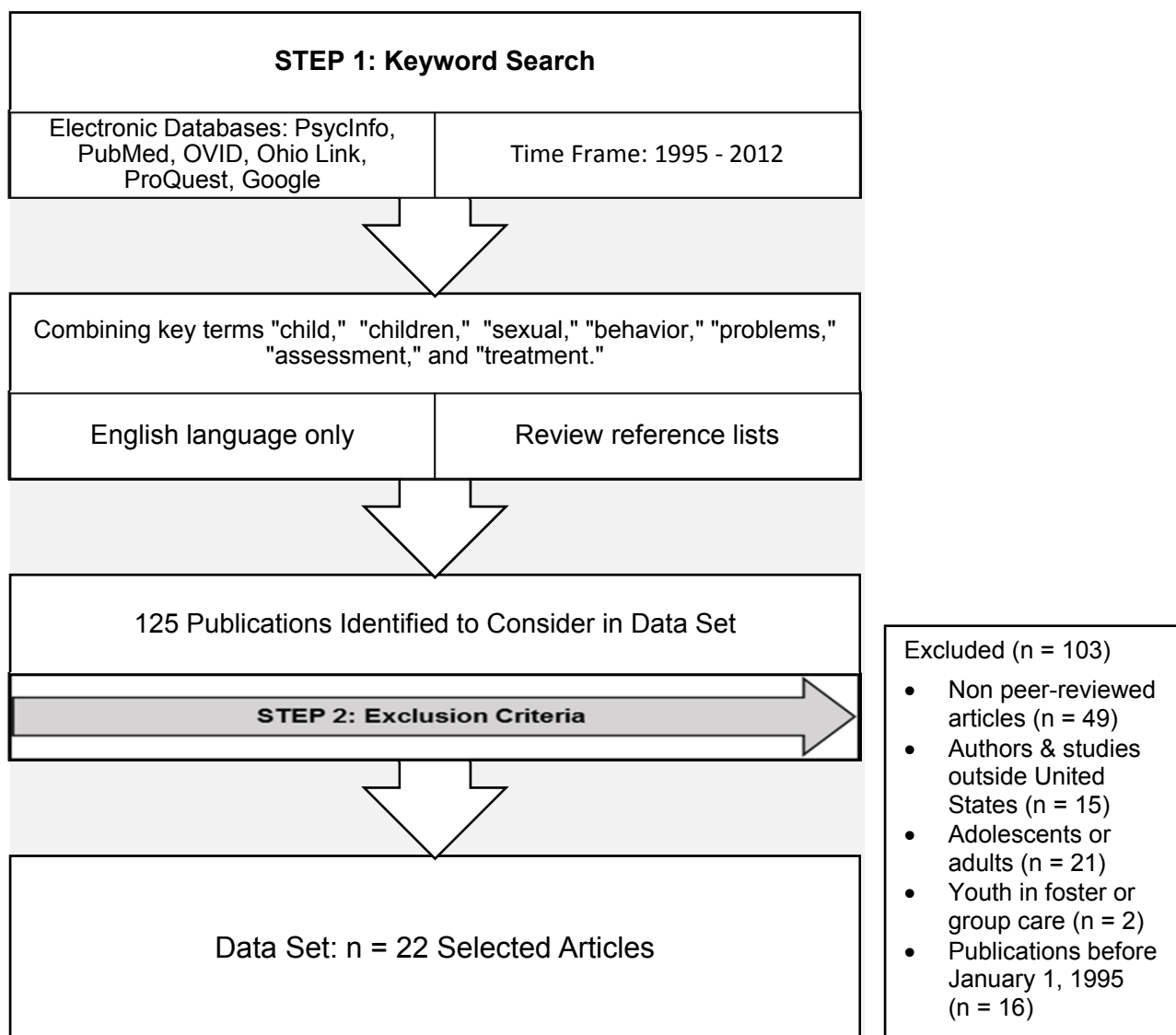


Figure 4. Flow chart of the secondary data collection process with exclusion criteria.

Literature was specific to preadolescent children, younger than age twelve; articles were excluded that blended subjects beyond twelve years of age. Blended studies lacked the particular emphasis needed for this study specific to children younger than twelve years. Additionally, excluded articles focused solely on children in foster care or residential programs. Once the secondary data collection process was finished, a process called bounding the view was conducted as part of the analytic plan.

Bounding the View

An important aspect of the analytic plan is defining the boundaries of the analysis. These are defined by the data source, the research approach and the questions asked in the study (Guest et al., 2012). Specific to this study, each selected source article constituted a secondary data set. Within each selected article, the specific components for analysis included the author's introduction or commentary, literature review, and discussion or summary. The analytic approach was explanatory which involved exploring the internal dynamics and structure of the subject of childhood sexual behavior. Following bounding the view the analytic process may begin. In an effort to protect the integrity of the study, rigorous procedures, and a compelling chain of evidence are maintained to help add credibility to the study.

In order to manage aspects of subjectivity throughout a study, Lincoln and Guba (1985) encourage ongoing debriefing with others familiar with the chosen methodology. Throughout this study, routine communication regarding the analytic process and procedures occurred with the dissertation committee, a content expert, academic faculty, and peers. This study followed a procedure guided by a six-phase process for thematic analysis.

Thematic Analysis: Six-Phase Guide

The general process of thematic analysis follows six-phases, suggested by Braun and Clarke (2006), which were expanded and applied to this study. The following briefly describes the overall process.

1) Familiarization with the data. Thematic analysis begins with familiarization and immersion in the data. This occurs through repeated reading of the data, or textual content, in an active way, looking for meanings and configurations without coding (Braun & Clarke, 2006). Memos and note taking began and occurred throughout the entire analytic process.

2) Generating initial codes. This is the initial process of identifying curious features or segments of the content data that captured attention and interest in relation to the points of inquiry of the study. In an effort to reduce risk of researcher bias, due to the continual involvement of the researcher as an instrument of the study, use of qualitative coding software or independent coders of the data is suggested (Goodwin, 2012). This study included one investigator; however, Dedoose (Socio Cultural Research Consultants, 2013, 2014) was the qualitative coding software program utilized as a tool for analysis intended to reduce bias.

Dedoose (Socio Cultural Research Consultants, 2013, 2014) is a web-based application for qualitative and/or mixed methods research developed by professors at University California Los Angeles. It is user-friendly and visual research tool considered effective across a wide variety of fields of study continually being expanded and updated (Socio Cultural Research Consultants, 2013, 2014). When using qualitative coding software segments of the reviewed text are tagged and named as codes. There is no limit

to the number of codes generated, which may evolve into potential themes or patterns. Braun and Clarke (2006) suggest data be generously coded, time permitting, with inclusion of a little surrounding data to maintain the context of the segment. They also recommend retaining contradictions or inconsistencies in the data and including them in the coding process.

3) Searching for themes. This phase begins once all data has been initially coded. At this point, usually a substantial list of codes exists. Codes are then sorted into a wide range of potential themes while collating all relevant data extracts within each sub-theme of thematic category. During this phase of analysis relationships between codes and differing levels of themes typically begin to emerge (Braun & Clarke, 2006). Some codes and themes may be discarded during this phase. Another option is to create a category of miscellaneous codes that may be applied later during the analysis process (Braun & Clarke, 2006).

4) Reviewing themes. Review is a process of refinement. During this phase of examination, themes are analyzed to determine whether there is coherence of the data within the theme or not. Braun and Clarke (2006) note that this involves a process of constant comparison; there may be movement during the process that involves combining, separating, refining and discarding. Ideally, data within themes should fit together in a meaningful way and there should be clear distinctions between themes. More precisely, coded extracts need reviewed with each theme to determine if they form a coherent pattern; if not then the coded data and theme need reevaluated for possible revision or discard (Braun & Clarke, 2006).

Once coded data is reviewed within subcategories, the next level of fine-tuning occurs as individual themes are assessed in relation to the entire data set and research points of inquiry. During this phase, recoding occurs which is expected as part of the refinement process. However, recoding is necessary only in relation to adding something new or substantial to the analysis process (Braun & Clarke, 2006). A sense of saturation occurs during this process when sufficient themes fit well together, and reflect the overall meaning of the data in relation to the research inquiry and analytic approach.

5) Defining and naming themes. The analytic process is nearing conclusion once there appears to be a comprehensive thematic map of the data. This is the culminating process for capturing the spirit of what each theme intends to represent with a final determination of what data fits within each theme (Braun & Clarke, 2006). The aim of this process is to “define and refine” by organizing themes and elaborating on how data extracts collected from the content, complement the explicit themes (Braun & Clarke, 2006). Themes are uniquely denoted and details supported from the data while simultaneously integrated with the research inquiries. Broad themes are also connected to sub-themes, defined as themes within a theme, and can be relevant in explaining details of complex or overarching themes. Completion of this process occurs when the researcher is able to clarify the scope and content of each theme in a few statements. Once achieved the researcher may elect to name the themes in ways that give the reader a quick sense of each theme, similar to a label or simple title (Braun & Clarke, 2006).

6) Producing the report. The final write-up of the report involves the task of drafting a document that clearly and convincingly conveys to the reader the outcomes of the analysis in a coherent, logical, and interesting manner. Typically, data extracts embedded within the document provide illustrations of themes that make a valid point or argument in relation to the research inquiry (Braun & Clarke, 2006). In this study, the write-up of the analysis culminated with the innovative conceptual design of an assessment for childhood sexual behavior.

Literature Review and Background

This chapter provides a brief overview on childhood sexual behavior and sexual behavior problems that emerged from a preliminary review of literature dating back to 1985. Familiarity with the background and topic of childhood sexual behavior provides the sociocultural context for comprehending varied conceptualizations of child sexual behavior problems in the United States. This overview illustrates the changing landscape of knowledge and understanding on child sexual behaviors influencing development of a conceptual model of assessment elaborated upon later in Chapter IX.

Sociocultural Framework: What is Normal?

Societal norms and values pose significant influence over interpretation of what constitutes normal and concerning childhood sexual behavior. Sexual behavior influenced by various factors, occurs across an array of environments or contexts. Developmental, familial, social, cultural, and religious attitudes and values, all influence child sexual behavior and development (Chaffin et al., 2008; Friedrich, 2007; Johnson, 1993; Johnson & Friend, 1995; Kellogg, 2010).

Discerning normal or typical, from maladaptive childhood sexual behaviors, patterns, or child-to-child interactions is challenging (Friedrich, 2007). As noted in existing literature (Friedrich, 1995a, 1997; Johnson, 1993, 2002; Johnson & Friend, 1995) normal childhood sexual behaviors characteristically involve an information gathering process (playing doctor), exploration of gender roles and behaviors (playing house), and involve children of similar age, size and developmental status. Participation in the sexual behavior is voluntary and occurs between children who mutually enjoy an ongoing friendship. Behaviors are limited in type and frequency, the child has balanced

interest in sexual acts and sexuality with other forms of play, and the behaviors that involve genital contact generally diminish in the presence of adults (Friedrich, Fisher, Broughton, Houston, & Shafran, 1998; Johnson, 1993, 2002; Johnson & Friend, 1995).

Comprehension of the diverse issues related to children exhibiting sexual behaviors begins by defining parameters of what constitutes a childhood sexual behavior problem. Professionals have historically used factors such as age, size, and power differentials to identify a particular behavior as abusive or not (Friedrich, 1997; Friedrich, Grambsch, Broughton, Kuiper, & Beilke, 1992; Johnson, 1993, 2002; Johnson & Friend, 1995). Araji (1997) suggested that child sexual behavior problems are deviations from the normal course of child sexual development. Extant literature described child sexual behavior problems as behaviors that involve sexual body parts or private parts (e.g., genital, anus, breasts, and buttocks). These parts are either their own or interactions with another child where there is substantial difference in age or developmental stage, advanced sexual knowledge, force or coercion, emotional distress, disruption in functioning, and some form of harm or the potential for harm (Araji, 1997; Chaffin et al., 2008; Gil & Johnson, 1993; Johnson, 2004; Shaw, 2000; Silovsky & Bonner, 2003).

Studies suggested problematic sexual behaviors occur more frequently, do not respond to limit-setting, do not decrease with feedback, are not age appropriate, interfere with normal child activities, often reflect adult sexual knowledge, and may be intrusive (Friedrich, 1995; Johnson, 1993, 2002; Kellogg, 2010). Typically, sexual acts with another child involving oral, vaginal, or anal penetration are distinguished as abnormal and problematic when exhibited by children (Chaffin et al., 2008; Heiman et al., 1998; Johnson, 2002; Johnson & Friend, 1995).

The complexity and limited knowledge of normal versus concerning sexual behavior, results in some adults and caregivers overreacting to a child's behaviors (Friedrich, 2007; Hornor, 2004; Kellogg, 2010). Heightened awareness and media attention directed at child sexual abuse, likely contributes to increased anxiety among caregivers and professionals when children exhibit sexual behavior involving another child (Heiman, 2001; Kellogg, 2010). Studies suggested that reactive responses resulted in negative effects on the parent-child relationship (Friedrich, 2007; Hornor, 2010) creating convoluted situations that resulted in limited and sometimes harmful outcomes for the child and parents (Chaffin & Bonner, 1998). By the mid-1990s, it was apparent to some professionals that communities and public policies in the United States had taken a punitive response toward children and adolescents identified with sexual behavior problems (Bonner et al., 1999; Chaffin & Bonner, 1998).

Chaffin and Bonner (1998) wrote an editorial outcry to the reactive and punitive response of communities and public policies against adolescents and children with sexual behavior problems. The combative response of communities seemed fueled by concerns that adult sex offender behaviors resulted from juvenile sex offenses, and child sexual behavior problems (Chaffin & Bonner, 1998). Research on childhood sexual behavior was scarce at that time. There was an absence of assessment and treatment models and empirical studies on children with sexual behavior problems. The central response to children exhibiting sexual behaviors derived from individual and collective beliefs rooted in American culture (Chaffin & Bonner, 1998). According to Chaffin and Bonner, ATSA endorsed the following position in response to the wide array of rigid beliefs, fears, reactions, and legal policies instituted in the absence of empirical support.

There is little evidence to support the assumption that the majority of juvenile sex offenders are destined to become adult sex offenders, or that these youths engage in acts of sexual perpetration for the same reasons as their adult counterparts. (p. 316)

This socio-cultural response elevated the need for more research and highlighted the necessity for increased capacity to differentiate childhood sexual behavior as normal versus maladaptive childhood sexual behavior. A comprehensive, contextual understanding of child development and child sexuality seemed critical. Unraveling the complexity of such behaviors was vital toward determining whether a child's behaviors were cause for intervention or concern.

Developmental Context: Child Sexuality and Sexual Development

Available contemporary research on child sexuality and sexual development, which encompassed diversity of ethnicity, race, gender, and sociocultural influences in the United States, was scant at the time of this study. Whether childhood sexual behavior is normal or not is a complex question. However, knowledge of child development seems essential in conceptualizing the function of a child's particular expressed action or behaviors. Therefore, consideration of the available empirical knowledge on childhood sexual development, within the framework of developmental theory, offers a preliminary guide for discerning the context and appropriateness of a child's behaviors and functioning. Childhood sexual development is concisely summarized here from a developmental perspective drawing from Erik Erikson's psychosocial theory of human development (1950, 1956, 1980, 1994) and Jean Piaget's cognitive developmental theory (Piaget, 1970; Piaget, Gruber & Voneche, 1977).

Erik Erikson's work reflects the significant inspiration of Sigmund Freud and Anna Freud, his daughter. Many consider Sigmund Freud as the most influential and

controversial figure in the field of psychology from the twentieth century. His theories have influenced the contributions of many great thinkers, particularly on views of personality, childhood, sexuality, memory, and therapy. Yet, controversy and criticism, which exceed the limits of this paper, plague Freud's psychosexual developmental theory and include concerns related to scientific validity, research bias, and gender, racial and ethnic bias (Berzoff, Flanagan, Hertz, 2008; Crews, 2006; Fisher & Greenberg, 1985).

The significance of Freud on Erikson's developmental theory reflects the influence of Sigmund Freud's psychoanalytic theory and psychosexual stages of development (Crain, 2011). Similar to Freud, Erikson believed personality develops across phases or stages. Yet, Freud's theory implied ego identity primarily occurs through psychosexual stages in childhood development with behaviors driven largely by psychosexual energy, or the libido (Leach, 1997). Erikson viewed development occurring across the lifespan, well beyond the childhood years.

Unlike Freud's psychosexual theory which focused on sexual modes and their consequences, Erikson's psychosocial developmental theory emphasized emerging ego qualities across a series of stages over the lifespan, shaped by social experiences within the broader context of society (Stevens, 1983). Consequently, the selection and application of Erikson's developmental theory that associates child development within the context and influence of ecological and social context is an appropriate choice for inclusion in this study.

Erikson's psychosocial theory purports that human development is life long and involves eight stage of development; each stage is associated with diverse challenges to master that build upon successful completion of earlier stages (Erikson, 1993; Stevens,

1983). When mastery of an earlier life skill is not successful, it is presumed to reappear as a challenge for the individual in their future development (Crain, 2011).

Erikson emphasized that a child acquires skills and attitudes resulting from successful negotiation of psychological conflict at each particular stage of development (1950, 1956, 1980, 1994). Therefore, a child's development stage provides a context for interpreting the behavior and functioning of that child. Although stage development relates to a typical age range, it is possible that a child's age and stage of development will be incongruent.

Jean Piaget's theory of cognitive development was selected for inclusion in this study based on the premise that a child's formative years occur as phases of development comprised of the child's experiences and interactions within their environment (Piaget & Inhelder, 1969). Piaget's work and contributions to psychology, the study of development, and education is extensive. In particular, his work and association with a constructivist theory of knowing fits well within this study (von Glaserfeld, 1990).

Piaget's theories on developmental psychology suggest that children *construct* their understanding of the world through active involvement and interactions within the world (Piaget & Inhelder, 1969). Various cognitive stages of development influence how the child creates understanding. Each new stage of cognitive development involves processes of differentiation, integration, and synthesis, whereby increasingly complex structures, or schemas, construct new knowledge and create meaning (Piaget, 1970; Piaget et al., 1977).

Subsequent processes known as assimilation and accommodation enable the child to consciously or unconsciously adopt or internalize the outside world (Piaget & Inhelder,

1969). Assimilation involves taking information and experiences from the outside world and incorporating them into one's internal world. Accommodation entails adapting new assimilated information within one's internal world, which can be a complex and challenging process (Piaget & Inhelder, 1969).

Childhood sexual development occurs within the context of a specific developmental stage and reflects sociocultural norms within the child's ecological environments. This study is based on extant literature selected from the United States of America. Therefore, much of the data represented in the research reflects participants from the dominant sociocultural context of European-American children from middle or lower income socioeconomic families. Consequently, this overview of child sexual development is drawn from the literature functions as a reference point for understanding what is known about child sexual development within a developmental context. However, it does not reflect the full spectrum of sexual development, nor does it represent norms of behavior that apply to all children.

An infant's earliest lesson about behavior derives from the caregiver-infant relationship (Erikson, 1950, 1980; Wood et al., 1996, 2007). Caregivers who respond and attend to their infant's physical and emotional needs in a nurturing, consistent manner provide a framework for development of trust and safety in the world (Erikson, 1950, 1980). The infant is completely dependent upon adults for care and emotional security; they need assistance to learn that the world is a safe and satisfying place (Wood et al., 1996, 2007).

Trust is the essential foundation for the successful mastery of this developmental stage (Erikson, 1950, 1956, 1980, 1994). This is accomplished through exploration of the

infant's environment, trusting one's own body skills, trusting needs will be met and safety maintained by caring adults (Wood et al., 1996, 2007). The infant's introduction to touch is by the primary caregiver (Finan, 1997; Smith, 1993; Wood et al., 1996, 2007). Recognition of affection occurs when nonsexual touch, nurturing contact, cuddling, and kisses are received between caregiver and infant (Smith, 1993).

Behavior from an infant is exploratory and sensory (Piaget, 1970; Piaget et al., 1977; Piaget & Inhelder, 1969). The infant learns to construct meaning from the world by coordinating sensory information and physical actions through exploration of the body, its functions, and various physical sensations. Piaget (1970; Piaget et al., 1977) called this period of cognitive development *sensorimotor*, when an infant progresses from reflexive, instinctual action to symbolic thought. Normal and typical sexual development for an infant might include genital exploration, penile erections, vaginal lubrication, and sensation from touch on the genitals, pelvic thrusting, and enjoyment in nakedness (Finan, 1997; Gordon & Schroeder, 1995; Johnson, 1993).

Infants learn to trust adults who satisfy their needs. They develop understanding of their physical body and the relationship between actions and consequences primarily through interactions with primary adults within their environments (Piaget, 1970; Piaget et al., 1977; Piaget & Inhelder, 1969; Wood et al., 1996, 2007). Infants learn pleasant sensations that occur from specific actions or behaviors such as gently rubbing the face with a soft blanket, sucking a thumb, or touching one's genitals (Finan, 1997; Johnson, 1993). These varied behaviors of self-soothing may occur as a mechanism to regulate and reduce tension and distress at this stage of development (Yates 1990, as cited in Johnson, 1993, p. 5).

From a developmental perspective, the toddler and preschool stage, two to seven years, is a period when children explore and strive for independence (Wood et al., 1996, 2007). Young children explore their environment with their senses and through physical contact. Behavior is the primary mode of expression, interaction, and communication. During the early toddler stage of this developmental period, toddlers develop a sense of autonomy and mastery of independent skills and ideally learn to respond to their environments with success (Wood et al., 1996, 2007).

Later in this stage, preschool age children are developing the capacity to take initiative to resolve feelings of powerlessness and guilt (Erikson, 1950, 1980; Wood et al., 1996, 2007). Piaget called this period of cognitive development *preoperational*, when a child utilizes images and words to represent the world with increased symbolic thinking that goes beyond sensory information or physical actions (1970, Piaget et al., 1977). These young children thirst for knowledge about everything and anything; sexual knowledge is no exception (Gordon & Schroeder, 1995; Johnson, 1993; Smith, 1993; Wood et al, 1996, 2007). An intense curiosity of one's own body emerges during this stage while awareness of social norms and self-control may also occur (Smith, 1993).

Pretending to play "doctor" or "house" are common themes of sexual play stemming from a combination of curiosity, role identification, and a desire to understand similarities and differences between the individual child and others (Finan, 1997; Gordon & Schroeder, 1995 Johnson, 1993). Generally, children aged two to five years exhibit more frequent and diverse sexual behaviors as compared with children older than five years (Friedrich et al., 2001). Typical sexual behaviors for children younger than age six might include: a) touch to one's own genital parts for a sensation of pleasure or soothing,

b) nudity, c) sexual exploration of one's own genitals or the genitals of a same-age friend or sibling, d) exhibitionism or exposing genitals, e) naming sexual parts, and f) using slang or "potty words" with peers (Finan, 1997; Gordon & Schroeder, 1995; Johnson, 1993; Smith, 1993).

School-age children, ages seven to eleven years old, strive to develop mastery of skills applicable within group settings (Wood et al., 1996, 2007). Developing competency of physical, intellectual, and social skills among peers is significant as comparison and competition among peers' increases (Erikson, 1980, 1994). Children place attention on their peer relationships and with greater awareness of their community rather than on their own bodies and its functions, as seen in younger aged children (Wood et al., 1996, 2007). School-age children develop the capacity to reason logically about concrete events and classify objects into different groups; this is the *concrete operational* stage of cognitive development (Piaget, 1970; Piaget et al., 1977; Piaget & Inhelder, 1969). Early in this stage of development, children typically have decreased sexual interests (Smith, 1993) and increased social interests (Wood et al., 1996, 2007).

With the onset of hormonal and physical aspects of puberty, a child's interest, and preoccupation with sexual knowledge and sexual behaviors, such as masturbation, sexual contact with peers, and sexual intercourse, typically increases through adolescence (Finan, 1997; Friedrich et al., 1991; Gordon & Schroeder, 1995; Smith, 1993). Before reaching 13 years of age, as many as 40 – 75% of children will participate in some type of sexual behavior (Friedrich et al., 1991; Johnson, 1993; Kellogg, 2010; Larsson & Svedin, 2002). Such behaviors may be unknown to adults. As children learn social norms and values, they adapt to social standards, and therefore may conceal their sexual

behaviors more. Thus, an accurate accounting of child sexual behaviors among school-aged children is difficult to gather due to reduced caregiver supervision, more time away from home, at school, and among peers (Kellogg, 2010).

The following Table functions as a reference point that summarizes highlights from the continuum of normative sexual development for children prior to puberty and sexual maturation.

Table 1

Summary of a Developmental Continuum of Childhood Sexual Behaviors

Age/ Stage	Sexual Development Birth to 2 years	Sexual Development 3 to 5 years	Sexual Development 6 to 12 years
SEXUAL KNOWLEDGE	<ul style="list-style-type: none"> • Displayed as mimicked or learned behavior. 	<ul style="list-style-type: none"> • Gender permanence • Gender differences are understood • Limited information about pregnancy, childbirth • Knows labels for parts but prefers slang • Uses elimination functions for sexual parts 	<ul style="list-style-type: none"> • Genital basis of gender • Knows accurate labels for body parts, uses slang • Awareness of sexual aspects of pregnancy • Increased sexual knowledge reflecting maturation and puberty
SEXUAL BEHAVIOR	<ul style="list-style-type: none"> • Genital exploration • Penile erections, vaginal lubrication • Genital pleasure is possible • Touches sex parts • Enjoys nudity 	<ul style="list-style-type: none"> • Masturbates for pleasure, may experience orgasm • Sex play with sibs or peers; shows genitals; explores own/others genitals • Enjoys nudity • Uses elimination words with peers 	<ul style="list-style-type: none"> • Masturbation, • Sexual Intercourse, • Physical aspects of puberty

Note. From Gordon & Schroeder, 1995; Smith, 1993.

Etiology of Child Sexual Behavior Problems

The term *sexual behavior problems* has various definitions that include a variety of behaviors. Whether or not the behavior is sexual and/or a sexual behavior problem seems influenced by sociocultural beliefs about child sexuality. These behaviors are often referred to as sexual behavior problems, particularly when the behaviors involve other children and are deemed intrusive or coercive and involve genital contact.

Understanding the complexities related to children identified with sexual behavior problems requires understanding more of what is going on with the child than simply the behavior identified as sexual. The context of the sexual behavior has relevance in determining whether the behavior is problematic or not. In the 1980s and 1990s, much of the early research on childhood sexual behavior suggested that children sexually victimized were the same children exhibiting sexual behavior problems (Friedrich, 1993; Friedrich & Luecke, 1988; Gray, Busconi, Houchens, & Pithers, 1997; Hall et al., 1998; Johnson, 1988, 1993; Kendall-Tackett et al., 1993; Lamb & Coakley, 1993).

Often, identification of a child's sexual behavior occurred in relation to their psychological treatment for sexual abuse (Friedrich, 1993; Kendall-Tackett et al., 1993; Johnson, 1996; Johnson & Friend, 1995). Such sexual behaviors might be solitary or interpersonal involving another child, and behaviors were viewed as inappropriate, aggressive, or intrusive (Chaffin et al., 2008; Friedrich, 1993; Gil & Johnson, 1993; Johnson, 1988; Kellogg, 2010). Early research found sexually abused children displayed various sexual behaviors more frequently than non-abused children (Friedrich, 1993; Johnson, 1988; Kendall-Tackett et al., 1993). Studies found that caregivers of sexually abused children reported that their children displayed significantly more sexualized

behavior as compared to their non-abused peers (Friedrich, 1993, 1995b; Friedrich, et al., 1992; Gale et al., 1988).

Researchers questioned the difference between sexually abused children who exhibited sexual behaviors compared with sexually abused children who did not (Bonner et al., 1999; Friedrich, 1993; Gale et al., 1988; Johnson, 1988). Results suggested that children who exhibited sexual behavior had experienced sexual abuse with greater frequency, and at a younger age, than children who did not exhibit sexual behavior (Friedrich, 1993; Johnson & Berry, 1989). Early theories emphasized sexual abuse as a primary factor related to sexual behavior problems in children; consequently, childhood sexual behaviors became a diagnostic indicator of child sexual abuse (Friedrich & Luecke, 1988; Gale et al., 1988; Johnson, 1993; Kendall-Tackett et al., 1993).

In the late 1990s, studies and additional factors related with children exhibiting sexual behavior problems began to gain attention. Research suggested that child sexual behavior problems were indicative of influences other than sexual abuse; results found that non-sexually abused children also displayed similar concerning sexual behaviors (Bonner et al., 1999; Pithers & Gray, 1998). One study suggested that 52% of children with sexual behavior problems did not have a reported history of sexual abuse and 41% did not have reports of any type of abuse (Bonner et al., 1999). Thus, even though sexually abused children appeared to act out sexual behaviors with greater frequency than non-abused children did, not all children exhibiting sexual behaviors were sexually abused (Bonner et al., 1999).

Beyond sexual abuse. By the beginning of the 21st century, studies expanded understanding of the complexity of influences affecting children with sexual behavior problems. Social, economic, familial, and developmental variables, as well as psychological issues, contributed to the etiology, intensity, and acuity of child sexual behavior problems (Chaffin, 2008; Chaffin et al., 2008; Chromy, 2007; Friedrich, 2007; Friedrich et al., 2005; K. Rasmussen, 2006; L. A. Rasmussen, 1999, 2004; Letourneau et al., 2004; Tarren-Sweeney, 2008). Others advanced the understanding that sexual knowledge, behavior problems, and family issues were frequently associated with child sexual behavior problems (Chaffin, 2008; Chromy, 2007; Friedrich, 2007). Research outcomes posited that problematic sexual behaviors resulted from a wide array of contributing factors that had no correlation to child sexual abuse (Bonner et al., 1999; Chaffin et al., 2008; Friedrich, 2007; Tarren-Sweeney, 2008).

Behavior and social-emotional issues commonly reported were interpersonal problems, immaturity, loneliness, distractibility, impulsivity, anxiety, aggression, poor emotional regulation, and limited problem solving skills (Friedrich 2007; Johnson, 1998; Letourneau et al., 2004). Externalized behavior problems commonly identified in studies on children with sexual behavior problems included distraction, impulsivity, hyperactivity, defiance, oppositional and aggressive behaviors. Studies noted symptoms for internalized behavior problems such as depression, anxiety, and post-traumatic stress disorder (Bonner et al., 1999; Friedrich et al., 1991). Research suggested diverse behavioral, social-emotional, and psychological problems significantly contributed to child sexual behaviors that occurred with greater intensity (Chaffin et al., 2008; Friedrich, 2007; Griffith, 2005).

According to research, children exhibiting problematic sexual behavior consistently evidenced higher levels of sexual interest and knowledge (e.g. desire to watch TV nudity) and had more knowledge about sexual acts than other children (Friedrich, 1997; Johnson, 2002; Johnson & Friend, 1995; Kellogg, 2010). These children displayed less defined physical and emotional boundaries and limits, self-stimulated more openly and more often, and were more aggressive or intrusive than their peers (Friedrich et al., 1998; Johnson, 1998, 2004).

Relational problems were found to be common among families of children displaying problematic or sexually aggressive behaviors (Chaffin et al., 2008; Friedrich, 2007; Friedrich & Luecke, 1988; Tarren-Sweeney, 2008). Overt sexual behavior such as family nudity, viewing pornography, and opportunities for children to view adult sexual acts or intercourse in the family were also associated with children exhibiting sexualized behaviors (Bonner et al., 1999; Friedrich, 1997; Friedrich et al., 1991, 1992; Letourneau et al., 2004). Other stressors at home and in the family included abuse (sexual or otherwise), caregiver substance abuse, mental health issues, and caregiver parenting styles (Chaffin et al., 2008; Friedrich, 2007; Letourneau et al., 2004).

Additionally, diverse exposure and responses to trauma and abusive situations, beyond sexual abuse, appears to have far-reaching implications on the development and functioning of children, and specifically their sexual behavior and relationships. Tarren-Sweeney (2008), in a study of 347 children in foster and kinship care, suggested that placement instability, exposure to multiple adversities, comorbidity, social problems, and relationship difficulties all affected children with sexual behavior problems.

Typologies: Children with sexual behavior problems. Various leaders in the field have attempted to develop a clinical typology, a systematic classification of types of behaviors, specifically for child sexual behaviors. However, to date there is no distinct profile for children with sexual behavior problems. Nor are there definitive factors that distinguish them from other groups of children (Chaffin et al., 2008). Children with sexual behavior problems are quite diverse in demographics, familial factors, economic status, and in their mental health and abuse histories. There were various attempts to design a typology, or subtypes, for childhood sexual behaviors. A brief sampling of these varied typologies from 1986-2002 follows.

Berliner, Manaois, & Monastersky (1986) developed one of the first typologies twenty-five years ago, identifying three categories of sexual behavior exhibited by children: 1) Precocious, 2) Inappropriate, and 3) Coercive. Later, Hall and Mathews (1996) proposed four categories of child sexual behaviors: 1) developmentally expected, 2) sexualized, 3) sexually intrusive, and 4) sexually offending. In 1999, Bonner and colleagues designed a typology from their research differentiating behaviors: 1) sexually inappropriate, 2) sexually intrusive, and 3) sexually aggressive.

Johnson (1998, 2002, 2004), designed a concise typology of sexual behavior for parents and professionals devised from her work with children that continues to be updated from her clinical work. Johnson differentiated sexual behaviors in three categories: 1) Natural and Healthy, 2) Of Concern, and 3) Seek Professional Help.

Pithers and associates (1998) organized their taxonomy to differentiate various types of children exhibiting problematic sexual behaviors. These five distinct groups, based on developmental stage and functioning among children presenting with sexual

behavior problems, were 1) sexually aggressive, 2) abuse reactive, 3) non-symptomatic, 4) rule-breaking, and 5) highly traumatized (1998).

More recently, Hall and colleagues (2002) endeavored to develop an empirical typology for children sexually abused that exhibited sexual behaviors. They identified five distinct sexual behavior groups: (1) developmentally expected and developmentally problematic (2) interpersonal, unplanned, (3) self-focused, (4) non-coercive (interpersonal, planned), and (5) coercive (interpersonal, planned).

In spite of the various attempts to construct distinct subtypes of child sexual behaviors there has been considerable overlap in the outcomes signifying there may be no actual distinct taxonomic subgroup for children with sexual behavior problems. Current thinking suggests the range of frequency and severity, rather than a particular subtype, may best define child sexual behavior as problematic (Chaffin et al., 2008).

Treatment Options

Fear that the child exhibiting sexual behavior problems will mature into an adult sexual predator has been a presiding concern for adults (Chaffin & Bonner, 1998). The emerging issue of sexual behavior problems among children and adolescents encouraged development of treatment models and studies. Many of the treatment models involved primarily adolescents and were not directly relevant to this study.

Although empirical studies on treatment models specific for children were relatively limited until the 1990s, empirical results implied that treatment related to childhood sexual behavior problems might not necessarily require complex, long-term treatment methods (Chaffin et al., 2008). Furthermore, these results demonstrated

successful outcomes for children exhibiting sexual behaviors regardless of their etiology (Bonner et al., 1999; Chaffin et al., 2008; Friedrich, 2007).

Bonner and colleagues (1999) conducted a phased controlled study from 1991-1998 with two hundred and fifty-three ($n = 253$) children and their caregivers. The purpose of the study was to develop a typology and compare the efficacy of two methods of treatment for a broad range of children ages 6-to-12 years. Of the 253 children, 201 were children with sexual behavior problems and the remaining 52 children had no known sexual behavior problems and served as a comparison group. The children and their parents or caregivers completed a battery of questionnaires and standardized tests to assess the child's affective and behavioral problems, cognitive ability, sexual behavior problems, and family functioning. Children were assigned to either a 12-session CBT based treatment group or a 12-session play therapy group. Results suggested children in both groups benefited from short-term reduction of sexual behavior problems and non-sexual behavior problems (Bonner et al., 1999).

In general, CBT, specifically short-term group modalities, showed evidence of reducing problematic sexual behavior among children (Chaffin et al., 2008; Cohen & Mannarino, 1997). When abuse is part of the etiology then treatment for trauma symptoms has been indicated. Studies suggest cognitive behavior modalities, particularly trauma-focused and abuse-focused CBT, were highly effective in treating trauma symptoms and in reducing post-traumatic stress disorder in children (Bonner et al., 1999; Cohen, Deblinger, Mannarino, & Steer, 2004; Cohen, Mannarino, Berliner & Deblinger, 2000).

Other effective modes of therapy included family-based treatment models and Multisystemic Therapy (L. A. Letourneau, Chapman, & Schoenwald, 2008). Primary caregivers and family environments significantly influence children's formative years; therefore, family context is at the center of treatment related to childhood sexual behavior (Friedrich, 2007). Friedrich realized the benefit of cognitive behavioral approaches in treatment of childhood sexual behavior problems, and concurrently noted equal significance for inclusion of the family context as essential for treatment (Friedrich, 2007).

Effective treatment interventions work for many children if treatment specifically addresses the problem behavior while also involving caregivers in the child's treatment (Chaffin et al., 2008; Friedrich, 2007). The ATSA Task Force concluded that evidence-supported interventions yielded the strongest benefit for children and their families (Chaffin et al., 2008).

Assessment Options

Effective treatment begins with a quality assessment, one that differentiates the nature of the problematic behaviors, whether the childhood sexual behavior necessitates treatment, and if warranted, what ecological interventions need developed for the unique needs of the child and family. Publications on early assessment models for child sexual behavior were scant in the extant literature. It appears that historically, assessment of childhood sexual behavior occurred as a diagnostic indicator in the context of child sexual abuse (Gale et al., 1988; Johnson, 1993; Johnson & Friend, 1995; Kendall-Tackett et al., 1993).

Gil & Johnson (1993) developed and published some of the earliest information and assessment guidelines on childhood sexual behavior and problematic sexual behaviors applicable in clinical settings. Often, assessment examined sexual behavior within the context of discerning whether the child was a victim of sexual abuse, and/or a risk to other children (Gil & Johnson, 1993; Johnson & Friend, 1995). Due to scarce empirical literature at the time, the authors cautioned that their assessment methods and results derived from clinical practice rather than empirical data (Johnson & Friend, 1995). Suggested use of Johnson's Child Sexual Behavior Checklist (Gil & Johnson, 1993) or the Child Sexual Behavior Inventory developed by Friedrich and colleagues (Friedrich et al., 1991) provided utility with gathering information about the child's sexual behaviors, yet there was no empirical support for either tool at that time (Gil & Johnson, 1993; Johnson & Friend, 1995).

Because assessment of child sexual behavior was frequently associated with child sexual victimization, it is not surprising that early assessment techniques for sexual behavior were similar to those used in assessment for child sexual abuse. For example, assessment included projective drawing techniques to identify genitals in a child's drawings, or informal observation of a child's play with anatomically correct dolls, and/or noting sexual behaviors exhibited during an unstructured clinical interview (Gil & Johnson, 1993; Johnson & Friend, 1995). These were informal and subjective methods that relied on the interpretation of the observer, few of these methods had empirical support.

Beyond these methods, core elements for assessment of childhood sexual behavior included clinical interviews with the parents and child, if verbal, and

observations of the child at play in a clinical office setting. Although these methods can be an efficient and effective means to obtain data, clinicians may inadvertently overlook key elements of functioning by these means alone (Meyer et al., 2001).

The turn of the 21st century yielded an increase in publications on assessment and treatment involving children older than age twelve labeled as juvenile or adolescent sexual offenders (Araji, 1997; Bonner, Marks, Thompson, & Michaelson, 1998; D. L. Burton, 2000; Chaffin, Letourneau, & Silovsky, 2002; L. A. Rasmussen, 1999, 2004; L. A. Rasmussen & Miccio-Fonseca, 2007). Questions of whether adolescent sex offenders were once children with sexual behavior problems was a driving area of concern (D. L. Burton, 2000). There appeared to be various tracks of research related to adult perpetrators, sexual offending adolescents, and children with sexual behavior problems occurring simultaneously.

Researchers and practitioners advocated for clinicians to assess childhood sexual behavior problems through a comprehensive, individualized process that assessed the child from a developmental perspective (Chaffin et al., 2008; Kellogg, 2010; L. A. Rasmussen, 2004; Shaw, 2000). Yet, specific assessment models or protocols for children applicable in an outpatient clinical setting continues scarce in the published literature. Primarily published assessment guidelines were within the context of an empirical study, involved adolescents, or applied primarily to inpatient, residential treatment programs. Assessments were seemingly rare and difficult to access particularly for use in outpatient settings.

Early in 21st century, ATSA formed a task force with the overall goal to identify effective components and models of assessment and intervention to guide professionals

in their work with children under 12 years of age who exhibit sexual behavior. The ATSA Task Force released the first report of its kind specific to children and adolescents. The report provided guidelines and recommendations on assessment, treatment, safety, placement recommendations, and public policy considerations (Chaffin et al., 2008). Kellogg (2009, 2010) and Shaw (2000) published guidelines for physician evaluations of children exhibiting sexual behavior problems for application in medical settings.

Clinical assessment intends to inform intervention and treatment planning and by nature is different from forensic assessment, which purposes investigation of child sexual abuse (Chaffin et al., 2008). The ATSA Task Force determined that consideration of timing, an ecological approach, and various assessment tools and components were necessary for a quality clinical assessment (Chaffin et al., 2008). The focus of assessment needed to expand beyond child sexual behavior to include other behavioral, emotional, or psychological symptoms (L. A. Rasmussen, 1999, 2004). Thus, formal testing seemed relevant as a tool to aid in estimating the extent and characteristics of a child's concerning sexual behavior (Chaffin et al., 2008; Friedrich, 2007).

Ultimately, contemporary research and clinical literature suggest that a child's problematic sexual behavior is one component of a disruptive behavioral pattern rather than an isolated issue (Chaffin et al., 2008; Friedrich, 2007; Heiman, 2001; Letourneau et al., 2004; Longo, 2003; L.A. Rasmussen, 1999, 2004; Tarren-Sweeney, 2008). The concept of child sexual behavior problems as occurring beyond sexual abuse, comprised of multidimensional and complex etiological factors, appears empirically supported (Chaffin, 2008; Chaffin et al., 2008; Friedrich, 2007; Griffith, 2005; Tarren-Sweeney, 2008). Therefore, it appears that treatment and assessment related to child sexual

behavior concerns and problems must consider the ecological influences affecting a child, as well as the possibility of sexual abuse or other forms of trauma.

Emphasis placed on evaluating context, social ecology, and family environment when assessing childhood sexual behavior appears essential (Chaffin et al., 2008; Kellogg, 2010). The causative influences of childhood sexual behavior problems are important for understanding a child's experience; yet, understanding the *context* of the sexualized behaviors is critical. A framework for deciphering childhood sexual behavior, as abusive or not, within a developmental perspective across an ecological context, is necessary for psychologists and clinicians, particularly a model which is applicable in an outpatient clinical setting. Detailed results from thematic analysis of selected articles from extant literature from 1995-2012 follow in the next chapter.

Results: Thematic Analysis

This study approached childhood sexual behavior problems from a theoretical perspective. The combined preliminary literature and analytic review of peer-reviewed articles spanned almost thirty years. Various experts and research teams forged unknown territory to explore and discern an effective understanding of this issue. This project builds upon the contributions of many of those pioneers to advance conceptual understanding and clinical assessment related to childhood sexual behavior.

The preliminary review of publications ($n = 125$) included literature such as peer-reviewed articles, treatment manuals, dissertations, and presentations that provided familiarity and context for the secondary source selection process. Table 2 provides a concise summary of the literature selected for analysis.

There were 70 initial codes from the twenty-two ($n = 22$) selected source peer-reviewed articles generated from the thematic analysis process. The majority of codes occurred multiple times, while a few emerged only a handful of times. Thematic analysis focused on the literature review, summarized results, discussion, conclusion, limitations and recommendations sections of each peer-reviewed source article. Throughout the analysis, there was a constant process of moving between points of inquiry and the data set, codes, and themes. Memos drafted simultaneously, captured thoughts as they emerged from the data and the coding experience. Higher levels of abstraction evolved and codes merged and collapsed into concept categories, also referred to as sub-themes, with elimination of less relevant codes.

Table 2

Summary of Selected Source Articles

Author(s) & Year	Literature Title	Journal Title	Description of Literature	Study Participants
Gray et al. (1997)	Children with sexual behavior problems and their caregivers.	Sexual Abuse: Research & Treatment	Quant: Pre-post Treatment - 5 yr Demonstration Site	(n = 72) - 6 to 12 yo + maternal caregivers
Chaffin & Bonner (1998)	Don't shoot: We're you children. Have we gone too far?	Child Maltreatment	Review & Commentary	Literature
Friedrich et al. (1998)	Normative sexual behavior in children: A contemporary sample.	Pediatrics	Quant: Comparative Study - Descriptive	(n = 1114) - 2 to 12 yo + female caregivers
Heiman et al. (1998)	A comparative survey of beliefs about "normal" childhood sexual behaviors.	Child Abuse & Neglect	Quant: Survey Study - Descriptive	(n = 210) - Adults: 33 students 36 med students 28 therapists/experts
Hall et al. (1998)	Factors associated with sexual behavior problems in young sexually abused children	Child Abuse & Neglect	Quant: Comparative Study	(n = 100) - 3 to 7 yo + caregivers
Pithers et al. (1998)	Caregivers of children with sexual behavior problems: Psychological and familial functioning	Child Abuse & Neglect	Quant: Descriptive study	(n = 72) - 6 to 12 yo + maternal caregivers
Gray et al. (1999)	Developmental and etiological characteristics of young children with sexual behavior problems	Child Maltreatment	Quant: Descriptive Study	(n = 127) - 6 to 12 yo + primary caregivers
Friedrich et al. (2001)	Child sexual behavior inventory: Normative, psychiatric, and sexual abuse comparisons.	Child Maltreatment	Quant: Comparative Study - RCT	(n = 1114) - 2 to 12 yo 620 - Sexual Abused (SA) 577 - Psychiatric Dx
Friedrich & Trane (2002)	Sexual behavior in children across multiple settings	Child Abuse & Neglect	Commentary: Review	Literature
Hall et al. (2002)	Sexual behavior problems in sexually abused children: A preliminary typology.	Child Abuse & Neglect	Hierarchical Cluster Analysis - Typology	(n = 100) - 3 to 7yo SA children
Silovsky & Niec (2002)	Characteristics of young children with sexual behavior problems: A pilot study.	Child Maltreatment	Quant: Pre-post Assessment & Treatment	(n = 37) - 3 to 7 yo + caregivers
Friedrich et al. (2003)	Sexual behavior problems in preteen children.	Annals NY Academy of Sciences	Quant: Correlational Study - Descriptive	(n = 2311) - 2 to 12 yo + primary female caregivers
Honor (2004)	Sexual Behavior in Children; Normal or Not?	Journal of Pediatric Health Care	Review & Case Study - Guidelines	(n = 2) - 4 & 5 yo
Carpentier et al. (2006)	Randomized trial of treatment for children with sexual behavior problems: Ten-year follow-up	Journal of Consulting & Clinical Psychology	Quant: Pre-post Treatment - RCT 10 yr	(n = 135) - 5 to 12 yo + primary caregivers
Silovsky et al. (2007)	Treatment for preschool children with interpersonal sexual behavior problems: A pilot study	Journal of Clinical Child & Adolescent Psychology	Quant: Pre-post Treatment - pilot study	(n = 85) - 3 to 7 yo + primary caregivers
Merrick et al. (2008)	Beyond sexual abuse: The impact of other maltreatment experiences on sexualized behaviors.	Child Maltreatment	Quant: Logistic Regression Etiology	(n = 690) - 8 yo + primary caregivers (no SA kids)
Silovsky & Letourneau (2008)	Introduction to special issue on children with sexual behavior problems: Dedicated to William F Friedrich PhD	Child Maltreatment	Review & Commentary	Literature
St. Amand et al. (2008)	Meta-Analysis of treatment for child sexual behavior problems: Practice elements and outcomes	Child Maltreatment	Quant: Mixed Linear Model Meta-Analysis	(n = 11) Studies on 18 specific treatments targets
Swisher et al. (2008)	Children with sexual behavior problems	Juvenile and Family Court Journal	Report: Literature Review	Literature
Elkovitch et al. (2009)	Understanding child sexual behavior problems: A developmental psychopathology framework.	Clinical Psychology Review	Literature Review: Ecological theory	Literature
Thigpen, (2009)	Early sexual behavior in a sample of low-income, African American children.	Journal of Sex Research	Quant: Descriptive Study	(n = 249) - 2 to 12 yo (n = 22) caregivers
Kellogg, (2009)	Clinical Report: The evaluation of sexual behavior in children.	American Academy of Pediatrics	Report: Literature Review - Guidelines	Literature

During the course of analysis and synthesis, further refinement of all data including excerpts, sub-themes, and memos occurred. Upon completion of analysis, distinct major themes and sub-themes emerged to help explain the significant patterns and meaningful responses to the inquiry points. The four major themes that resulted from analysis included a) Child Sexuality: Ecological Context, b) Developmental Context, c) Complex Trauma, and d) Ecological Interventions. Table 3 provides brief descriptions of each major theme, bulleted sub-themes, and the conceptual implications related to childhood sexual behavior. The following sections elaborate on each theme, sub-themes, and related coded concepts. Quoted excerpts provide examples for enhanced understanding of the meaning derived from review and analysis of the data.

Core Theme-Child Sexuality: Ecological Context

Child Sexuality: Ecological Context is a major theme which emerged early in analysis. This major theme refers to the candid view that the conception of childhood sexual behavior problems as socially constructed. Scant evidence exists on child sexuality and sexual behavior in the United States that is definitive, empirically studied, and relevant to the modern 21st century child.

Among almost thirty years of studies related to sexual behavior problems of children there was a lack of data providing empirically supported guidelines that discern typical or normal childhood sexual development and sexuality. However, concerns related to a child's aggressive, coercive, or threatening behaviors, identified as sexual behavior problems, were evident. Data suggested interpretation of a child's behavior as sexual, and abusive or intrusive, as heavily influenced by sociocultural beliefs and values of predominantly adult professionals and caregivers.

Table 3

Themes, Descriptions and Implications

Theme:	Description	Conceptual Implications
<ul style="list-style-type: none"> • Sub -Themes 		
Child Sexuality: Ecological Context <ul style="list-style-type: none"> • Child Sexual Development • Sociocultural Influence 	<p>Child sexuality includes biological and developmental factors such as age, gender, and cognition. As well as biological, psychological and social influences reflecting various constructed beliefs and values representing a particular time, place, and social culture.</p>	<p>Socially constructed expectations significantly affect conceptualization of problematic sexual behaviors. Differentiating normal or concerning behavior within a developmental and socio-cultural context needs careful consideration during child assessment.</p>
Developmental Context <ul style="list-style-type: none"> • Biological Factors • Complex Family Dynamics • Parenting Capacity 	<p>Developmental Context involves the co-occurrence of behavioral and social-emotional maturation of a child. Biological factors such as age, gender, race, and cognition, along with neurological, genetic, and environmental factors affect child development. The parent-child relationship and family ecology influence interpersonal interactions, emotions, and behavior that function as either protective or risk factors.</p>	<p>Familial factors, parenting capacity, and socialization greatly affect a child's biological, neurological, social, and emotional development and adaptive functioning. Assessment of the parent-child relationship, parenting capacity, complex family issues, and social-emotional skills of the child are essential components of an ecological assessment.</p>
Complex Trauma <ul style="list-style-type: none"> • Child Maltreatment and Trauma • Psychological and Emotional Distress 	<p>Complex Trauma is the chronic exposure of extreme suffering and distress, across time, which often includes forms of maltreatment, abuse, or neglect. Child abuse affects the developmental process. Children exhibiting sexual behaviors evidence exposure to multiple forms of trauma occurring within, and between, diverse environments.</p>	<p>Children affected by trauma often display emotional and behavioral problems, affect regulation issues, PTSD, poor boundaries, impulse control issues and social immaturity. Assessment of psychological distress and trauma are critical to discern, along with risk and protective factors for the child and family, to promote the safety and success of the child and family.</p>
Ecological Interventions <ul style="list-style-type: none"> • Effective Treatment • Clinical Assessment 	<p>Ecological Interventions account for a child's development and adaptive functioning within various environmental systems or contexts, which directly and indirectly affect the child's well-being. Interventions inclusive of parents yield effective and positive outcomes.</p>	<p>An integrated ecological approach for assessment of child sexual behavior concerns embraces the concept that a child does not develop or function in isolation. Developmental and ecological influences need considered as potential risk and protective factors essential for interventions.</p>

Child Sexuality: Ecological Context is a core theme that illustrates the significance of biological, psychological, and social influences, which affect sexual development of a child from infancy until sexual maturity. Socially constructed values become standards and norms, which heavily influence perspectives on defining parameters of what constitutes normal or maladaptive behavior and functioning. Reactions and responses of individuals and communities influence expectations of childhood behavior and determine what is normal and what is not.

Sociopolitical systems and institutions that maintain power and opinions of the dominant culture uphold the norms as standards. Yet standards of behavior may not accurately apply to all individuals due to various unique factors and social cultures. It appears from the findings of analysis that many assumptions regarding child sexuality and development were antiquated and based more on social and cultural standards than empirical evidence.

The review of data highlighted a gap in the extant literature of a modern conceptualization of what constitutes childhood sexuality and sexual behavior problems. Two sub-themes, labeled a) Child Sexual Development and b) Sociocultural Influence emerged early during the coding process and continued to be refined throughout analysis. Four conceptual categories contained within Child Sexual Development included a) Conceptualize CSBP b) Normal or Not c) Socialization, d) Family Sexuality, and e) Exposure to Sexual Content. Four categories related to Sociocultural Influence include a) Reactions and Stereotypes, b) Ecological Context, c) Labels and Stigma, and d) Sociopolitical Systems. Figure 5 illustrates the numerical details of associated codes with themes and sub-themes that emerged from the data as related to this core theme.

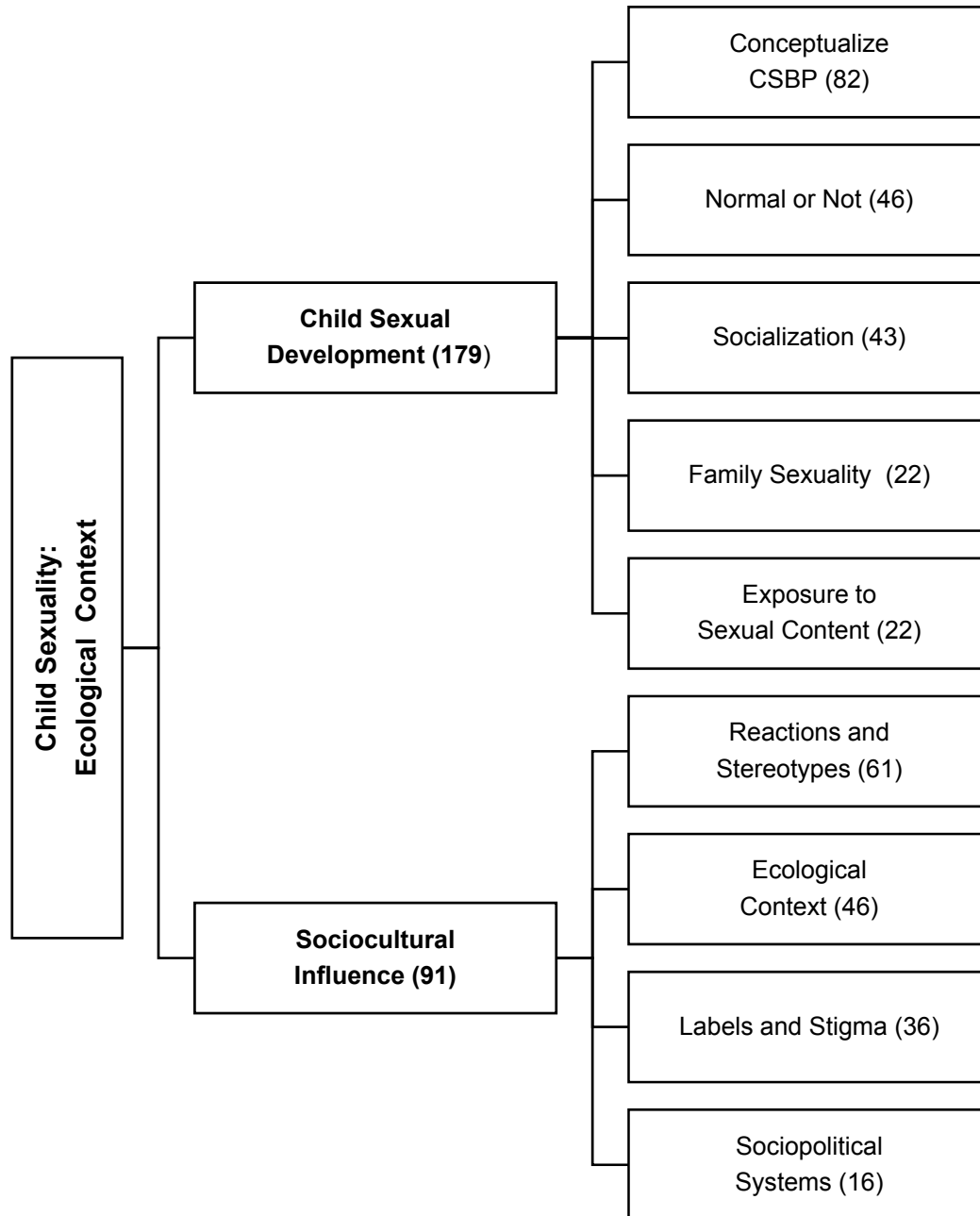


Figure 5. Child sexuality: Ecological context: Theme, sub-themes, and concepts.

Sub-theme: Child Sexual Development and related concepts. Child Sexual Development appeared early and throughout the data. Content tagged with this code occurred 179 times.

Remnants of a romanticized image of children as innocent and pure, and therefore, devoid of any sexual desires, arousal, or erotic interests remain deeply embedded within the culture and the psyche. Langfeldt (1990) suggested that due to the diverse beliefs and attitudes around sexuality within society, combined with the lack of markers to guide parents, children are often left to themselves to decipher the parameters of acceptable sexual behaviors. (Heiman et al., 1998, p. 290)

The following examples from the data highlight socially constructed beliefs that contributed to a distorted depiction of childhood sexuality and sexual behavior.

Western society continues to view children as innocent and pure, lacking any sexual desires, thoughts, or interests. These beliefs are embedded deep within the culture. (Heiman et al., 1998, as cited in Horner, 2004, p. 58)

Sexuality is widely accepted as a fundamental and important dimension of human life, but few empirical studies are available regarding the sexual behavior of children. Contributing to this paucity of research is a cultural belief in the sexual innocence of children and an attendant commitment to its protection that emerged with the conceptualization of childhood as a distinct period of life characterized by purity, innocence, and faith. (Bullough, 2004, as cited in Thigpen, 2009, p. 67)

Literature about children's sexual knowledge, interests, and experiences in relation to their own bodies and interaction with others remains limited. Some investigators speculate that the paucity of research on childhood sexual behavior when compared to other areas of child development reflects a culture that is profoundly ambivalent about human sexuality. (Heiman et al., 1998, p. 290)
These influential social values and beliefs significantly affect the overall

paradigm and view of childhood sexuality and sexual behavior. Socially constructed beliefs shape the responses of adults, and social and political systems that affect children and families in the United States.

Coded category: Conceptualize CSBP. The process of discerning characteristics of child sexual behavior problems (CSBP) refers to the category Conceptualize CSBP. This category was tagged 82 times during the coding process. These concepts reflect the complexity subsequent to the absence of contemporary information on child sexual development and sexuality. The following excerpts reveal the implications of

Conceptualize CSBP and the diversity of opinions, which further contribute to uncertainty of what defines a child's sexual behavior as problematic, or not.

The ATSA definition of CSBP emphasizes the role of culture, noting that developmentally inappropriate sexual behaviors occur at a greater frequency than would be culturally expected. However, we know very little about the influence of culture on child sexual behaviors, both normative and problematic. (Elkovitch, Lutzman, Hansen, & Flood, 2009, p. 596)

Both literatures critically speak to the difficulty of identifying problematic sexual behavior in children in the absence of knowledge of typical ranges of sexual behavior. (Thigpen, 2009, p. 67)

Moreover, it is likely that children who fall outside of the class of sexual behavior in which no sexual behavior is observed are most at risk for having their behavior labeled as atypical in accordance with cultural notions that children are asexual in thought and behavior. (Thigpen, 2009, p. 78)

Some data revealed varied opinions of concern that a child's sexual behaviors were indicative of future adult sexual offending behavior. Concerns about future offending behaviors inadvertently influenced theoretical conceptualizations of childhood sexual behaviors as revealed in the following excerpts.

Rooted in the juvenile justice work and related to attempts to understand the developmental pathways of sexual offending behaviors this work has conceptualized (sexual behavior problems) SBP in childhood as a pre-cursor to later sexual offenses. (Silovsky & Niec, 2002, p. 187)

Other studies also suggest that perpetrators may act out their own abuse experiences in their abuse of others. (Briere, 1989; Cantwell, 1988; Gil, 1987; Haugaard & Tilly, 1988; Johnson, 1988a; Knopp, 1985; Ryan, 1989a, as cited in Gray et al., 1997, p. 270)

Other data differed, revealing opposition to perceptions that children function as small versions of adolescents or adults.

There is no evidence that sexual behavior of children, which on the surface appears similar to adolescent and adult sexual behavior, is functionally the same behavior with the same meanings. (Hall et al., 1998, p. 1047)

Further, it is important to note that while the term sexual is used, the intentions and motivations for these behaviors may or may not be related to sexual gratification or sexual stimulation. (Elkovitch et al., 2009, p. 589)

These quotes specifically highlight varied beliefs of what constitutes a child's sexual behavior problem (SBP) and the etiology of the behavior. Some theorize that childhood sexual behavior is diagnostic of sexual abuse, while others suggest a more complex conceptualization.

One model stems from the conceptualization of SBP as indicative of traumatic sexualization. (Cunningham & McFarlane, 1991; Finkelhor & Browne, 1985; Friedrich, 1993, as cited in Silovsky & Niec, 2002, p. 187)

Sexual victimization during childhood may be an etiological factor related to childhood sexual behavior problems. (Gray et al., 1997, p. 268)

Several etiologies likely exist for children with sexual behavior problems, some of which may not involve sexual victimization. (Gray et al., 1997, p. 270)

Although sexual abuse impacts the development of SBP, many children with SBP have no known history of sexual abuse. (Silovsky, Niec, Bard & Hecht, 2007, p. 379)

Data revealed uncertainty about the etiology and implications of childhood sexual behavior, and what constitutes problematic sexual behavior. Yet, data seemingly revealed some consistencies about the context of behaviors considered maladaptive and worrisome.

Problematic sexual interactions between children seem to be characterized by dominance, coercion, threats, force, aggression, and compulsivity as opposed to sexual play that is spontaneous, light-hearted, and mutual in nature. (Gil & Johnson, 1993, as cited in Heiman et al, 1998, p. 291)

Behaviors that involved oral, vaginal, or anal penetration were judged by a majority of adults to be abnormal sexual behaviors in children under 13 years of age. (Heiman et al, 1998, p. 289)

It is important to explore the frequency of the behavior, whether the child can be redirected from the behavior, whether the child can limit the behavior to appropriate places and times, and whether the sexual behavior is causing a disruption in the child's life. (Horner, 2004, p. 63)

Although definitions of SBP vary, they are typically conceived of as persistent and developmentally atypical sexual behaviors. (Carpentier, Silovsky & Chaffin, 2006, p. 482)

Considerable variation in the data contributes to challenges in discerning whether exhibited child sexual behaviors are within a normal developmental continuum, or if they may be abusive, harmful, or problematic. The following examples from the data reflect ambiguity surrounding childhood sexual development within the United States.

This review confirms the lack of a simple, unitary etiologic explanation for CSBP and highlights the dynamic interplay among and between risk and protective factors both within and across ecological domains. (Elkovitch et al., 2009, p. 590)

Very little continues to be known about typical sexual behavior in children. (Thigpen, 2009, p.77)

The limited understanding of normative development discussed above has posed a challenge to adequately understanding and defining abnormal or problematic child sexual behaviors. (Elkovitch et al., 2009, p. 588)

Maladaptive behavior must be viewed in relation to what is considered normative behavior for a given developmental time point. (Cicchetti & Sroufe, 2000, as cited in Elkovitch et al., 2009, p. 595)

While there is much to learn and clarify regarding childhood sexual behavior, some agreement on what constitutes problematic sexual behavior was noted in the data.

SBP do not represent a syndrome or diagnosable condition, but rather a set of behaviors. (Carpentier et al., 2006, p. 482)

SBP are deviations from the normal course of sexual development. Social context, individual characteristics, disruptive experiences, and the interactions of these factors impact the course of sexual development. (Araji, 1997, as cited in Silovsky et al., 2007, p. 377)

According to the data, child sexual behavior problems represents a range of behaviors involving private parts or genitals that are persistent, developmentally atypical, and intrusive or harmful in some manner either self-directed or involving another child, often younger that do not respond to adult redirection (Chaffin et al., 2008; Swisher et al., 2008). Elkovitch and colleagues (2009) reviewed the historical concept that links sexual abuse and sexual behavior. Their review of literature revealed various studies that consistently endorsed higher levels of sexual behavior problems among children who had been sexually abused. However, they also reported many of the studies did not isolate psychiatric issues, and those that did found psychiatric issues to be a significant factor correlated with child sexual behavior problems.

Analysis of the data suggests that the outcomes of empirical studies were dependent upon the design and participants explored in the study. The data on child sexual behavior problems, explored beyond child sexual abuse, showed ample evidence that child sexual behaviors were multidimensional, with many correlating factors strongly related to varied forms of traumatic stress, externalized behavior problems, and familial factors and deficits.

Coded category: Normal or Not. The coded category Normal or Not was tagged in the coding process 46 times. The following quotes point to the association between the social construction of child sexuality and sexual behavior, and challenges posed by the absence of definitive standards of normal childhood sexual development and exploration.

Lamb and Coakley (1993, as cited in Heiman et al, 1998) point out, the term normal carries different meanings; “In one sense, `normal' means typical, occurring in the general population. The other meaning of `normal' is more value-laden. It implies that the behavior somehow promotes health, or at the very least is not detrimental to one's well-being” (p.523).

A sexual behavior may be normal and not typically occurring, but still healthy, or may occur commonly, but not be appropriate. (Heiman et al, 1998, p. 301)

For example, there is no consensus regarding what constitutes “normal” sexual behavior over the developmental stages of childhood. (Hall et al., 1998, p. 1047) Defining the boundaries of normal childhood sexual behavior is an ominous task since so much of what is deemed “normal” is determined by the social, cultural, and familial context. (Heiman et al, 1998, p. 289)

Challenges are evident when attempting to frame child sexual exploration as a component of sexual development within a range of normal or atypical behavior. It seems apparent from the data that sexual development, similar to other developmental tasks and stages, occurs on a continuum.

The results were extremely consistent with earlier research, and clearly indicate that children exhibit numerous sexual behaviors at varying levels of frequency.....and most likely is a reflection of the fact that sexual behavior and other behaviors occur along a continuum, with overlap occurring in children who are at either extreme. (Friedrich et al., 1998, p. 6)

Typical sexual development can also involve children touching each other’s private parts and genital areas. Typical sexual play is exploratory in nature and it occurs spontaneously, intermittently, by mutual agreement, and without coercion or strong feelings of anger, anxiety, fear, or sadness. Moreover, typical sexual behavior occurs among children of similar age, size and developmental level. (Swisher et al., 2008, p. 51)

These limited retrospective studies indicate that children engaged in episodes of sexual play, and experienced feelings of sexual excitement and arousal with these activities. (Heiman et al, 1998, p. 292)

Illustrated from data is the considerable variation in the developmental continuum of childhood sexual behavior, particularly when reported retrospectively by adults.

Frequencies of childhood sexual behaviors retrospectively reported by adults may differ from frequencies contemporaneously reported by parents; recollection differences through time, personal acceptance of sexual behaviors as normal, and the extent to which the behavior is covert may explain some of the discrepant results. (Kellogg, 2009, p. 993)

Most of the survey respondents (*85% of college female undergraduates*) reported a childhood sexual game experience, with one-third of the group describing a sexual situation involving genital fondling (either with or without clothing). (Heiman et al., 1998, p. 291)

Of significance was the perception by adults that their childhood sexual experience produced feelings of arousal (26%) or feelings of sexual excitement (43%). For those adults who described a sexual game . . . 57% of these women felt 'aroused' and 73% acknowledged feeling 'excited.' (Heiman et al., 1998, p. 291)

Despite methodological differences, these studies indicate that broadly defined sexual experiences between children are common; 42 to 94% of young adults across a wide range of studies report sexual experiences as a child. (Elkovitch et al., 2009, p. 588)

Children engage in a wide array of sexual behaviors across their development most of which do not constitute sexual behavior problems or abuse (Gray et al., 1997). Yet the data showed relative agreement on the lack of consensus around defining child sexuality within a developmental context of contemporary culture in the United States. Until future research provides an accurate representation of childhood sexuality and sexual behavior, psychologists and clinicians need to work with the information available to discern the best outcome for children and families when these issues present.

Coded category: Socialization. In conjunction with biological factors, socialization also affects sexual development and child sexuality. The coded categories a) Socialization and b) Normal or Not, were highly related to each other and the sub-theme Child Sexual Development. Socialization occurred in the data 43 times during the coding process.

Socialization describes a developmental and lifelong process of accruing skills, behaviors, and values necessary for participating in society (Clausen, 1968; Macionis, 2012). Socialization reflects individual functioning prescribed within social and cultural

standards developed and displayed across diverse environments such family/home, peers/school, community, and greater society. Socialization occurs through and within social interactions and experiences that provide context for mastery of developmental skills necessary to thrive and survive (Macionis, 2012).

Erikson (1950, 1980, 1994) conceptualized socialization as occurring across the lifespan, as previously mentioned in Chapter V. Each stage of development offers opportunities to master a specific social-emotional skill. Primary adults within a child's ecological environments have significant impact on the development of socialization skills. For the child, this developmental process begins with the interpersonal interactions within the scope of parents, family, and extended family, later expanding to peers, school, and other social networks that broaden with the developmental process.

Interactions with family and peers, particularly values related to boundaries and rights of others, have an effect upon childhood sexual development and behaviors as illustrated in these following excerpts.

Thus the family environment of children with interpersonal sexual behavior problems is not only more abusive physically and emotionally, but also the boundaries regarding the rights of others, privacy, sexuality, and autonomy appear to be more problematic. (Hall et al., 1998, p. 1056)

Particular attention should be given to the role primary caregivers play in socializing their children toward (or away from) particular types or modes of sexual expression. (Thigpen, 2009, p. 78)

These rules include sexuality, and children learn at young ages that some types of behavior are meant to occur in private settings, if at all. They learn these rules via modeling, shaping reactions from adults and others around them, as well as language used to describe behaviors as acceptable or not. (Friedrich & Trane, 2002, p. 245)

Social modeling and practice of sexual behavior appear to be associated with interpersonal sexual behavior problems (witnessing other children/siblings being abused, child-to-child sexual activity, and the child's role in that activity). (Hall et al., 2002, p. 301)

Peer relations and interactions within day care and school environments affect development of social skills and personal boundaries that may compliment or contrast skills learned within the family and primary home environment.

However, children in day care are likely to be exposed to children who have been raised by parents whose attitudes toward child-rearing may be quite different than their own parents. Peer socialization around sexuality is as likely as other processes that are mediated by peers. The relationship of children's sexuality to hours in day care may reflect more chances to interact with children who vary regarding sexuality. (Friedrich et al., 1998, p. 7)

Such overt behaviors decline with age, in part because of the socialization process whereby children tend to adopt cultural and societal mores as they enter middle childhood. (Friedrich et al., 1998; Friedrich et al., 1991; Lindblad et al., 1995; Sandnabba, Santilla, Wannas, & Krook, 2003, as cited in Merrick, Litrownik, Everson, & Cox, 2008, p. 123)

Stigmatizing responses from adults, particularly caregivers, may impede these children's developing self-concept. Poor impulse-control skills, other aggressive behaviors, and inaccurate perceptions of social stimuli in some children with SBP further hinder social relationships and cause problems at school. (Araji, 1997; Friedrich & Luecke, 1988; Gil & Johnson, 1993; Horton, 1996, as cited in Silovsky & Niec, 2002, p. 196)

Concerning gender, varied sociocultural influences affect perceptions of gender in relation to childhood sexual behavior. Beyond biological factors, socialization directly relates to gender roles within the larger sociocultural context. Illustrated from the data analysis is the following example.

The socialization process regarding sexuality reflects a 'dual culture.' Males are 'socialized to be able to focus their sexual interest around sexual acts isolated from the context of the relationship,' while women focus on the whole of the relationship and more readily and 'more completely distinguish between sexual and nonsexual forms of affection' (Finkelhor, 1984, p. 12). This socialization process coupled with women's primary responsibility for childrearing is likely to

sensitize the sexes differently regarding their perception of what constitutes normal and abnormal childhood sexual behavior. (Heiman et al., 1998, p. 300)

The relevance of the coded category of Socialization to childhood sexual behaviors and discerning problem sexual behaviors demands consideration of context and the diverse ecological influences affecting the child's display of sexual behavior. The necessity for conceptualization of childhood sexual behavior within a context that supports normalization of sexual behavior, rather than pathologizing sexual behaviors or labeling them as predatory or offending behaviors, seems evident.

Coded categories: Family Sexuality and Exposure to Sexual Content. Aside from the differentiation of child sexual behavior, there are influences that highly affect childhood sexuality and a multiplicity of sexual behaviors exhibited by children. Specifically, family sexuality and exposure to sexual content, both highly influence child sexual behavior. These concept categories emerged from the data in relation to the sub-theme Child Sexual Development as a) Family Sexuality and b) Exposure to Sexual Content. Each occurred 22 times in the coding process.

The concept Family Sexuality refers to the values, attitudes, and behaviors specifically regarding sexuality and sexual behavior that occur within the family system. From the data, the following examples reveal the implications and influence of Family Sexuality on childhood sexual development and sexual behavior.

Family values and behavior have a major impact on the development and expression of sexual behavior in children. (Friedrich, 1990 as cited by Gray et al., 1997, p. 271)

The more direct pathway, is that a more relaxed family attitude regarding nudity or observing adult sexuality, results in children in that family being more likely to exhibit sexuality. It may also be that a greater openness and honesty about one's own sexuality is related to more disclosure about one's child's sexual behavior. (Friedrich et al., 1998, p. 7)

Both life stress and family sexuality have been found to be significant correlates of sexual behavior in both normative and clinical samples. (Friedrich et al., 1991, as cited in Friedrich et al., 2001, p.41)

The familial sexual culture, beliefs, attitudes, customs, knowledge, sexual decision making, and risk taking, comes to bear on the sexual development and behavior of children in that it is likely to contain important messages about what it means to be sexual for given individuals at a particular time in life. (Thigpen, 2009, p. 78)

Exposure to Sexual Content is the category that surfaced from the data referring to a child's exposure to a range of sexual behaviors and sexually explicit content that exceeds the child's developmental maturity and age-related experience. Such exposure includes experiences like viewing sexually explicit material images, videos, or witnessing adult sexual activities; as well as, witnessing sexual contact between children or witnessing sexual abuse. These examples highlight the relationship between the concept categories of Family Sexuality and Exposure to Sexual Content.

Child sexual behavior problems are consistently associated with early, age-inappropriate exposure to sexual behavior or knowledge. (Bonner et al., 1999; Friedrich et al., 1991, 1992, 2003, as cited in Elkovitch et al., 2009, p. 595)

Children are repeatedly exposed to sexual images in our erotic society, for example, on television and in movies, yet parents are reluctant to discuss sex with their children because of cultural beliefs that children lack sexuality and because they hesitate to discuss sexual practices in general. (Horner, 2004, p. 58)

Children have access to sexually explicit material through various venues such as printed material, television, cinema, and the internet. Being uncensored and monitored only by the adults in a child's particular environment (i.e., school, home, community), this material is extremely challenging to limit and control.

Gil states that problematic behaviors are often a result of exposure to explicit sexual behavior or material in or out of the home. (Hornor, 2004, p. 60)

The media also influence the sexual development of children. Children today have greater access to more forms of media than ever before. (Hornor, 2004, p. 57)

Reinforce with parents the importance of supervising the amount and content of media to which their children are exposed. (Hornor, 2004, p. 62)

Family Sexuality and Exposure to Sexual Content were associated with concerning childhood sexual behavior as noted in the following examples.

Parents who endorsed family sexuality, which includes items related to nudity, opportunities to witness sexual intercourse and look at pornographic magazines/movies, co-sleeping and co-bathing, also reported higher levels of sexual behavior in their children, regardless of whether the child had a history of sexual abuse. (Friedrich et al., 2003, as cited in Elkovitch et al., 2009, p. 595)

The influence of sexually explicit internet content and the effects of contemporary media exposure upon child sexual development is a field worthy of exploration and research. This new arena of research exceeds this study; however, data revealed the following common concern.

Brown & Cantor (2000, as cited in Hornor, 2004) say that three truths exist regarding children and media: media are a dominant and influential and an increasingly important force in our culture; youth are active media consumers who choose, interpret and apply media in a variety of ways; and media are increasingly interactive and multisensory. (p. 57)

All agree that much remains to be learned about the effects of sexual content in the media on children and adolescents. (Horner, 2004, p. 58)

Sub-theme: Sociocultural Influence and related concepts. The sub-theme Sociocultural Influence occurred over 91 times and was frequently associated with concepts related to Child Sexual Development. Sociocultural Influence was highly related to the major theme Child Sexuality: Ecological Context, as representative of the mechanisms contributing to the socially constructed perceptions and responses of adults and institutions in relation to childhood sexual behaviors. Related categories from the

data include a) Reactions and Stereotypes, b) Labels and Stigma, c) Sociopolitical Systems, and d) Ecological Context.

Coded category: Reactions and Stereotypes. Data reflected strong support that children exhibit sexual behavior across a wide developmental continuum. Findings also supported normalcy as a concept determined by adult responses and interpretations. Stereotypes and sociocultural opinions affect children and families' lives in significant and sometimes traumatic ways. Data coded as Reactions and Stereotypes, emerged 61 times. This example from the data suggests that adult perceptions, beliefs, and reactions discern whether childhood sexual behavior is deemed problematic and pathological, or not.

Attitudes and beliefs about what constitutes healthy and normal childhood sexual behavior or abnormal and pathological childhood sexual behavior affect how adults respond to children's behaviors. (Heiman et al., 1998, p. 292)

Adult perceptions of child sexuality and sexual development affect their observations and interpretations of childhood sexual behavior. Parental attitudes and responses shape a child's sexuality and development, with the risk of instilling a sense of shame and secrecy, as illustrated in these examples from the data.

Adult attitudes about sexuality and normal childhood sexual behavior will affect how the adult responds to a child's sexual behavior. A parent who views sex as dirty, sets rigid limits, and punishes a child for sexual behavior considered healthy in children may instill guilt or shame in his or her child. On the other hand, parents who have no sexual boundaries can give rise to sexual acting out in their children. (Hornor, 2004, p. 57)

Gagnon and Simon (1973, 2005) theorized that sexual behavior is not prominent among children partly because parental reactions morally condition children toward sexual secrecy and shame until adolescence, the developmental period in which sexual capacity is culturally recognized. (Thigpen, 2009, p. 76)

Since children are socialized in our culture, however, to inhibit the public display and expression of their sexual behavior, it would be expected and not surprising if adult observations of children's sexual behaviors underestimated the typical and normal patterns of exploration, experimentation, and sexual activity. (Heiman et al., 1998, p. 291)

Varied sociocultural influences inform adult reactions toward childhood sexual behaviors. Findings suggested prominent dynamics affecting adults included familial and sociocultural beliefs on sexuality and genital contact, knowledge of sexual development, parent education level, and a history of childhood sexual abuse or trauma. Studies have shown that mother's with higher levels of education were found to define their child's sexual behavior more often as normal, compared to mothers with less education who were more likely to observe their child's sexual behavior as abnormal or concerning (Friedrich et al., 1998; Heiman et al., 1998).

It was found that as children grow older, there is a wider range of opinions about which sexual behaviors were acceptable, and these opinions were affected by characteristics such as professional affiliation, age, gender, political attitude and child rearing practices. (Haugaard, 1996, as cited in Heiman et al, 1998, p. 293)

Parents and caregivers concerned about child safety learn from each other and information generated within society. Parenting attitudes and responses shape a child's sexuality, sexual expression, and sexual development as illustrated in these examples.

The large amount of attention sexual abuse has received in professional literature and the lay media has made parents feel unsure about the correct way of responding to child sexuality. (Sandfort & Cohen-Kettens, 2000, as cited in Hornor, 2004, p. 59)

Given the limited knowledge of common sexual patterns in children, the possibility exists that adults will under react and minimize problematic sexual behavior as normal experimentation, or over react and pathologize typical behavior as deviant. Without normative data about children's healthy sexual behavior and development, adults are likely to impose their own personal standards. (Heiman et al., 1998, p. 292)

The absence of comprehensive information disseminated consistently about child sexual development, child sexual abuse, and other influences affecting child development, leaves adults to construct and/or adopt beliefs and opinions commonly represented in society. The data revealed diverse persuasions affecting adult views of child sexual behavior. The following excerpts point to the relationship between socially constructed gender norms and biases, connected with moral values and opinions, which affect adult perspectives and conditioning of their children in relation to sexuality.

Researchers have suggested that adults experience more anxiety over girls' displays of sexual behavior than boys, and that adult reactions inhibit sexual expression of girls. It follows that the behavior of girls may be pathologized when it falls outside of cultural norms pertaining to appropriate gender role behavior. (Thigpen, 2009, p. 78)

The more often the sexual games involved cross-gender experience, the more likely the game was perceived as manipulative or coercive. (Friedrich et al., 1998, p. 2)

A caregiver's reaction to a child's sexual behavior often affects the child's behavior and may result in reduction, concealment, or exacerbation of the particular behavior (Chaffin et al., 2008; Heiman et al., 1998; Kellogg, 2009). Caregiver discomfort with sexuality or a child's sexual behavior may result in emotional overreaction, interpretation, and description of the sexual behavior as abnormal, or maladaptive, when in fact it may not be.

Some caregivers struggle to respond appropriately to their child's behaviors due to their own history of childhood victimization or adult trauma. This parental hyper-vigilance may then affect the caregiver's capacity to make sound parenting decisions that drive fear-based reactions, resulting in exposure of their child to unnecessary sexual abuse investigations and physical examinations. Dubowitz and

associates (2001) study revealed mothers who experienced both sexual and physical abuse as more likely to suffer from depressive symptoms and use harsh parenting techniques (verbal aggression and minor violence) than mothers who were not abused.

Other data imply that determination of whether or not a child's behavior is viewed as problematic or abusive appears significantly predisposed and largely dependent upon the opinions of adult(s) involved with the child and their role, such as parents, teacher, or another professional from the child's ecological environments.

It is clear from examination of extant literature that the type of informant (e.g., parent vs day care provider) and type of experimental design (e.g., informant vs retrospective self-report) impacts the frequency of sexual behaviors reported. (Elkovitch et al., 2009, p. 588)

Professionals working with sexually abused children rated certain sexual behaviors as more abnormal than adults participating in a human sexuality course... Females also judged many of the sexual behaviors to be more abnormal than males. (Heiman et al., 1998, p. 289)

Thus far, data point to an array of complex elements associated with childhood sexual behavior. First, there is the absence of contemporary empirical evidence and knowledge of what actually constitutes normal sexual development for children in the 21st century United States of America. Second, there exists various sociocultural influences from community environments such as school and childcare, peers, media and the internet, which affect child sexuality and sexual experimentation. Thirdly, values and behaviors within the family system related to sexuality affect the child's behaviors, and the adult's perceptions and reactions to the child and their behaviors.

The intricacy of these concepts labeled Sociocultural Influences drew attention to the multidimensional aspects of this issue and the daunting nature of the professionals' role involved in unraveling these concerns.

Professionals' attitudes and beliefs about childhood sexuality is extremely critical, since their judgments of age inappropriate sexual knowledge and behavior is a key criterion used to assess allegations of sexual abuse. (Heiman et al., 1998, p. 292)

The implications of the data suggest the complexity of the dynamic interplay between professionals, and children and families presenting with sexual behavior concerns. Adults may inadvertently perpetuate misguided understanding or stereotypes that convolute circumstances.

Sexual behavior exhibited by children can be a source of anxiety to parents. (Hornor, 2004, p. 63).

Sexual behavior in children can cause uncertainty in the clinician because of the relationship between sexual abuse and sexual behavior. (Friedrich et al., 1998, p.1).

Since parents and others working with children (e.g., teachers, youth workers) often turn to helping professionals to gain an understanding of whether a child's sexual behavior falls within normal bounds, it is imperative to know what professionals view as normal or age appropriate sexual behavior. (Heiman et al., 1998, p. 293).

In fact, under close scrutiny, sexual abuse appears to be a frequent but not essential contributor to sexual behavior problems in both teens and adults (Chaffin & Friedrich, 2000, as cited in Friedrich et al., 2003). Unfortunately, the clinical community, who often react to a child caught in an adult-like sexual act as if she/he must be a sexual abuse victim, only variably absorbs this knowledge. (p. 96)

Findings that proposed fear-based reactions toward problematic childhood sexual behaviors identified as pathological are unsupported, and potentially damaging to the child as highlighted in the following example.

However some argue that professional intervention in the lives of these children maybe unwarranted or even harmful because of the risk of 'pathologizing' what might simply be exploratory sexual behavior. (Kilpatrick, 1987, 1992; Levine, 1996; Okami, 1992, as cited in Hall et al., 1998, p. 1046)

Results suggest a wide disparity of socially constructed beliefs, empirical knowledge of childhood sexual behavior, and what constitutes normal versus maladaptive behavior. Individuals, families, communities, social-political systems and institutions, uphold many conflicting values and beliefs with conviction. These variances result in inequality in adult responses and reactions to children exhibiting sexual behavior (Chaffin & Bonner, 1998; Elkovitch et al., 2009; Thigpen, 2009).

Coded category: Labels and Stigma. The related concept Labels and Stigma reflect a sociocultural dynamic that emerged from the data. This category occurred 36 times during the coding process. Labels and Stigma frequently linked with related concepts from the data such as Reactions and Stereotypes and Sociopolitical Systems. Language and labels bear significant influence in social construction of common beliefs and values. Labels promote stereotyping and assumptions that lead adults to follow a particular path that points to conclusions that may be quite inaccurate.

When a child exhibits sexual behaviors viewed as threatening, harmful, or associated as aggressive or sexually offensive, then actions follow in reaction to the perceived safety concerns. This is particularly common if the behavior exhibited by the child reflects adult sexual content, involves penetration, force, or results in harm to self or another (Chaffin et al., 2008; Heiman et al., 1998; Hornor, 2004; Kellogg, 2009). Adults respond to fear that children exhibiting problematic sexual behavior foreshadows the child as an adult sex offender (Silovsky & Niec, 2002).

Rooted in the juvenile justice work and related attempts to understand the developmental pathways of sexual offending behaviors, this work has conceptualized SBP in childhood as a precursor to later sexual offenses. (Ryan, 1997, as cited in Silovsky & Niec, 2002, p. 188)

This fear seems to perpetuate the use and application of labels such as predatory, sexually aggressive, or sexual offender when children exhibit concerning sexual behaviors. The impact of labeling children as sexually aggressive or perpetrators has the potential for long lasting and dire consequences for the developing child and family (Chaffin, 2008; Chaffin et al., 2008). The following examples illustrate the stigma and harmful implications of applying labels to children exhibiting sexual behaviors.

Stigmatizing responses from adults, particularly caregivers, may impede these children's developing self-concept. (Heiman, 2001, as cited in Silovsky et al., 2007, p. 379)

Labeling of this nature can delay permanency and complicate decision-making. Foster families may be unwilling to foster a child who is labeled a 'sexual offender' and juvenile justice officials may be unwilling to parole a juvenile with a history of SBP to the home or the community even though he or she successfully completed treatment. (Swisher et al., 2008, p. 56)

'Perpetrator', 'offender', and related terms when used with children with SBP are not only legal malapropisms but also potentially detrimental to children's developing self-concept. (Silovsky & Niec, 2002, p. 188)

Unfortunately, such labels been applied to children exhibiting behaviors deemed sexual and problematic; yet not all behavior deemed as sexual is problematic or evidence of psychopathology or dysfunction (Chaffin, 2008; Chaffin et al., 2008). From the data, findings suggest that children are not the same as adolescent or adult offenders.

It is doubtful that public policymakers have an accurate understanding of the low risk that children with SBP have for future sex offenses (Chaffin, 2008). Indeed, a prevalent myth exists that children with SBP (sexual behavior problems) are on a path to becoming adult sex offenders. (Swisher et al., 2008, p. 60)

It is clear that the majority of children with SBP do not continue to demonstrate problematic sexual behaviors, including sexual offending, into adolescence and adulthood. (Caprentier et al., 2006; Letourneau et al., 2008, as cited in Elkovitch et al., 2009, p. 596)

Children with SBP have been erroneously perceived as uniquely in need of specialized services specifically for sex offenders. (Swisher et al., 2008, p. 60)

In contrast, communities do not readily label children acting out due to impulse control, attention disorders, or behavioral problems as offenders. Nor does law enforcement or child welfare services remove them from their homes because they might act out, harm, or offend someone in the future (Chaffin, 2008). Yet, these experiences occur with children exhibiting sexual behaviors.

Professionals working with children with SBP need to avoid labeling children due to the far-reaching and long-term impact that certain labels (e.g., sexual offender, sexual perpetrator, child molester, etc.) can have. (Swisher et al., 2008, p. 61)

The data revealed that effective treatment interventions and outcomes for children exhibiting problematic sexual behavior indicate they pose a low risk for future sexually offensive behaviors. One recent empirical study demonstrated that children treated for sexual behavior problems were no more likely to offend sexually against others than children who previously had no history of sexual behavior problems (Carpentier et al., 2006). The following example highlights the connection and contrast between empirical findings and social cultural beliefs affecting conceptualization of children and sexual behaviors.

Children with SBP were no more likely to have future arrests for sexual and non-sexual offenses than a comparison group of children who had been seen for common non-sexual behaviors (e.g., Attention-Deficit Hyperactivity Disorder, learning problems) who had no reported SBP. The rates for future sex offenses/child welfare report of sexual abuse perpetration were only 2-3% for both groups. (Swisher et al., 2008, p. 55)

Given that a short-term, low burden CBT was found to reduce long-term sex offense risk to baseline general clinic populations levels, the findings raise doubts about policies and practices founded on the assumptions that these children have difficult to modify and persistent risk. (Carpentier, et al., 2006, p. 488)

Caution is warranted when applying labels to children, particularly prior to assessment or a comprehensive understanding of the child and their behaviors.

Terminology and labels can evoke reactions and fears that have potential to stigmatize causing the child and family undue harm and distress (Mukolo, Heflinger, & Wallston, 2010). The following quoted excerpt illustrates the significant implications of labeling and pathologizing in relation to children and sexual behavior.

Applying labels of "child perpetrator" to children's sexual interactions with other children has drawn particularly heated debate. Okami (1992) has suggested that sexual abuse experts have over pathologized children's sexual behavior and focused on negative aspects of sexuality, "casually" interchanging terms such as unusual and inappropriate with victimizing or perpetration "without reference to established baseline norms" (p. 112). Okami (1992, p. 126) goes on to speculate that: activism within this crusade against 'child perpetrators of abuse' may have the effect of stimulating long entrenched cultural tendencies to respond to childhood sexuality with exaggerated, near hysteric alarm, thus contributing to the occurrence of another form of childhood sexual trauma: adult overreaction to discovery of voluntary peer sexual interactions. (Heiman et al., 1998, p. 293)

The concepts Reactions and Stereotypes, and Labels and Stigma co-occur with a third concept labeled Sociopolitical Systems. This sub-theme represents the social structure and political systems that establish legal and social standards operating within local communities, state, and federal institutions. These include agencies such as child welfare services, social and health services, law enforcement, and legal systems such as juvenile justice and dependency courts.

Coded category: Sociopolitical Systems. The related category, Sociopolitical Systems, represents the social structure and political systems that maintain power and organization within society. Sociopolitical Systems as a coded category appeared 16 times in the data and was highly related to the concepts labeled Reactions and Stereotypes, and Labels and Stigma.

Sociopolitical Systems refers to the infrastructure and processes instituted that establish and maintain standards of society, regulations, and laws intended to support the whole of society. Concerning children, there are specific systems and institutions charged with the safety and well-being of children and families. Specific to children with sexual behavior problems, there are often diverse systems that may intervene and become involved with a child and family. According to the results of this study, the response of such systems may inadvertently perpetuate stereotypes and labels as seen in this example.

The question now is not whether we have gone too far—that point was passed long ago. The question now is when or how we will find our way out, and how many children and youth may be needlessly harmed before rational, fact-based policies and practices supersede the minimization of our past and the moral panic of the present. (Chaffin., 2008, p. 111)

Results from data analysis suggest contemporary concerns that institutional systems and policy makers may have gone too far regarding children with sexual behavior problems, as seen in these quoted examples from this study.

In recent years, a trend has developed to apply public policies originally developed for adult sex offenders to juveniles with inappropriate and/or illegal sexual behavior. (Swisher et al., 2008, p. 60)

Available research suggests that with completion of appropriate treatment, children with SBP are at a very low risk for having further problematic sexual behavior. For this reason, public policy should reflect the very low risk of children with SBP when making decisions about application of the Adam Walsh Act and national lifetime registries in general. (Swisher et al., 2008, p. 62)

Policies placing children on public sex offender registries or segregating children with SBT may offer little or no actual community protection while subjecting children to potential stigma and social disadvantage. (Chaffin et al., 2008, p. 200)

With the implementation of the Adam Walsh Child Protection and Safety Act signed into law in 2006, communities across the United States exist where children with sexual behavior problems as young as 10-years-old, may be subject to sex offender

registration laws and neighborhood notification (Chaffin, 2008; Chaffin et al., 2008; Elkovitch et al., 2009; Thigpen, 2009). Title 1 of the Adam Walsh Act (AWA), also known as the Sex Offender Registration and Notification Act, intended to protect children from sexual predators and offenders by requiring national registry for adults and juveniles under a sex offender classification and registry system (Enniss, 2008; Farley, 2008; McPherson, 2007). Under AWA, even low-level offenses require classification for anyone convicted of “an offense that has an element involving a sexual act or sexual contact with another,” (Farley, 2008, p. 487). Each state determines how and if they will comply and implement the federal law.

Ultimately, AWA is a response to public fears based in media and sociocultural perceptions that juveniles identified as sex offenders threaten society (Enniss, 2008; Farley, 2008; Spooner, 2011). The argument posited, similar to the logic applied to children exhibiting sexual behaviors, was that juvenile offenders are adult sex offenders in the making and are extremely likely to reoffend (Chaffin, 2008; Spooner, 2011). Perhaps the confusion among those who argued youth were at high risk to reoffend and become adult sex offenders was the result of reasoning backwards. Retrospective studies on adult offenders found that many adults could trace their early onset of sexually offensive behavior to adolescence or childhood (Marshall, Barbaree, & Eccles, 1991). This information may have led to the conclusion that most children exhibiting sexual behavior problems would ultimately become adult sex offenders, and therefore required interventions in the same manner as adults. However, this form of backward reasoning is likely risky and inaccurate.

Twenty-five years ago, ATSA endorsed the position that there was “little evidence to support the assumption that the majority of juvenile sex offenders are destined to become adult sex offenders or that these youth engage in acts of sexual perpetration for the same reasons as their adult counterparts” (ATSA, 1997, as cited in Chaffin & Bonner, 1998, p. 316). Data from this study further supported this belief as noted in this example.

It is clear that the majority of children with SBP do not continue to demonstrate problematic sexual behaviors, including sexual offending, into adolescence and adulthood. (Elkovitch et al., 2009, p. 596)

However, assumptions evolved into rigid sociocultural beliefs that set in motion an array of reactions and legal policies intended to protect communities that seemed lacking in empirical support (Enniss, 2008; Spooner, 2011). Although there was an influx of scientific data to inform decision-making and public policies, many developed policies appeared based upon false assumptions and misguided beliefs (Chaffin & Bonner, 1998).

Current research showed rates of recidivism for juvenile sex offenders were between 4-20% (Lobnov-Rostovsky, 2010). One study of 11,219 juvenile sex offenders followed over 59 months, found a 7.08 % sexual recidivism rate compared with a 43.4% general recidivism rate (Caldwell, 2009). Additionally, evidence suggests that biological, neurological, cognitive, and social development of juveniles and children differentiates their culpability and capacity as compared with adults (Enniss, 2008; Letourneau, Bandyopadhyay, Sinha, & Armstrong, 2009). Despite contemporary research, the reactive response of communities seemed fueled by concerns that adult sex offender

behaviors trickle down to childhood, and therefore apply to juvenile sex offenses and child sexual behavior problems.

Effective policy should recognize that children are naturally less culpable than adults. Children with SBP are vastly different than adult sex offenders with regard to motivation, origins of the behavior, co-occurring behaviors, future risk for sex offending, and responsiveness to treatment. Moreover placing children with SBP on a national public sex offender registry may offer little or no community protection while stigmatizing a child's life. (Swisher et al., 2008, p. 61)

There are certainly valid cases involving youth whose behavior toward self or another child results in physical harm or, emotional or psychological distress; however, these extreme cases are not representative of the majority of children exhibiting sexual behaviors (Chaffin, 2008). Reports estimate that approximately 2-3% of children act out in a manner identified as problematic sexual behavior (Carpentier et al., 2006; Chaffin et al., 2008). Data revealed awareness that further distances the behavior of children from those of adolescent or adults.

Although the conduct of children with SBP might appear initially to justify a delinquent or criminal charge, children aged 3 – 12 are distinct from adolescent and adult sexual offenders in the following ways: (a) rarely is sexual gratification a motivation for BP; (b) the SBP often occur in the context of complex family systems; and (c) SBP respond readily to treatment. (Swisher et al., 2008, p. 60)

It seems public fears continue to be fueled by concerns of child sexual abuse rather than scientific evidence that demonstrated the overall rate of child sexual abuse in the United States has declined over the past 25 years (Finklehor & Jones, 2006; Lobanov-Rostovsky, 2010). Actions taken in response to fear have far-reaching repercussions and must not be underestimated. This quote from the data represents the harmful implications related to sociopolitical policies based on socially constructed beliefs.

Building a body of knowledge in this area is extremely important because some state child welfare systems enacted procedures that register, segregate, and monitor children identified as having SBP to include placing children on lifetime public sex offender registries and Internet sites. (Carpentier et al., 2006; Thigpen et al., 2003, as cited in Thigpen, 2009, p. 77)

Embodied within the category of Sociopolitical Systems, are findings from the data representing the convolution of these issues. Matters of public policy and social responses such as stereotypes and labels toward childhood sexual behavior problems have broad implications, more complex than can be adequately addressed here.

Heightened awareness of the repercussions of such fearful reactions and the significant impact on children, families, and communities necessitates change. Findings thus far represent the multidimensional aspects of childhood sexuality and sexual development within the contemporary United States.

Coded category: Ecological Context. Ecological Context is the fourth related concept within the sub-theme Sociocultural Influence. As a code, Ecological Context appeared 46 times in the data and was frequently associated with related concepts of Sociocultural Influence, Conceptualize CSBP, Normal or Not, and sub-theme Child Sexual Development. The specific implication of this concept was the essential consideration of environmental influences upon child development and sexuality. Context refers to the socially constructed beliefs and views that form a lens of interpretation by adults toward children and sexual behavior. Language such as situational, contextual, environmental, milieu and cultural factors are associated with the concept of Ecological Context as revealed in the following examples.

The milieu in which a child develops (including cultural norms, practices, and beliefs) is likely to influence developmental course and the dynamic interplay of risk and protective factors. (Elkovitch et al., 2009, p. 596)

Context and role responsibilities often influence and sensitize professionals to particular aspects of an issue. (Heiman et al., 1998, p. 293)

There remains only a limited amount of literature regarding children's sexual knowledge, interests, and experiences. What is deemed "normal" child sexual behavior is determined by the social, cultural, and familial context of the times. (Heiman et al., 1998; Larsson & Svedin, 2001, as cited in Hornor, 2004, p. 58)

In addition, contextual factors, such as culture, may also impact the display and reported frequency of sexual behaviors, as culturally-specific values and expectations for children may influence and modify a child's behavior. (Rothbaum et al., 2000, as cited in Elkovitch et al., 2009, p. 588)

Context also refers to the framework of occurrence and influence surrounding behavior that affects the meaning and function of the behavior. Therefore, Ecological Context is a concept associated with the importance of defining the circumstances and contextualizing the significance and function associated with behavior, beliefs, and values. The following excerpts from the data highlight the importance of this concept.

Social context, individual characteristics, disruptive experiences, and the interactions of these factors impact the course of sexual development. (Araji, 1997, as cited in Silovsky et al., 2007, p. 377)

Contextual factors, such as the sexual culture within the family, should receive attention, as DeLamater (1987) asserted that the family as an institution has a particular ideology about the nature of sexuality and its function and purpose. (Thigpen, 2009, p. 78)

Even the most unusual of the sexual behaviors are present in some nonabused children and can be interpreted as benign, given their context of occurrence. (Friedrich, 1993, p. 8, as cited in Heiman et al., 1998, p. 291)

Sexual behavior of children should be examined in context, not isolation. (Friedrich et al, 2000, as cited in Hornor, 2004, p. 59)

These findings not only underscore the necessity of identifying contextual factors emanating from the child's environment that may explain variance in sexual behavior but also ascertaining a child's motivation for engaging in behavior, as children at different stages of development are likely to be motivated for and experience sexual behaviors differently. (Thigpen, 2009, p. 78)

Despite the gaps in extant literature and disparity within sociocultural beliefs about child sexual behavior problems, various adults and community professionals, specifically psychologists and clinicians, must address the needs of children presenting with sexual behavior concerns.

The next section of results examines data from empirically and clinically derived knowledge, specifically related to children identified with sexual behavior problems. The following section expands on themes derived from the data elaborating on the varied influences related to child sexual behavior problems.

Core Theme-Developmental Context

Early in the coding and analytic process, Developmental Context emerged as a core theme. This major theme represents the stages of development for a child shaped and informed by biological, familial, interpersonal and community systems. The theme Developmental Context encompassed three sub-themes that represent diverse ecological systems affecting child development. Related sub-themes include a) Child: Biological Factors, b) Parenting Capacity, and c) Complex Family Dynamics. Figure 6 provides illustrated details of the theme, sub-theme, and concept categories with the numerical details associated with codes applied during the analysis.

Sub-theme: Child: Biological Factors and related concepts. The sub-theme Child: Biological Factors emerged over 87 from the data. The sub-theme, Child: Biological Factors includes related concepts from the data named a) Age/Stage, b) Gender, c) Race/Ethnicity, and d) Cognition. The concept categories Age/Stage and Race/Ethnicity were also strongly associated with the sub-theme Child Sexual Development.

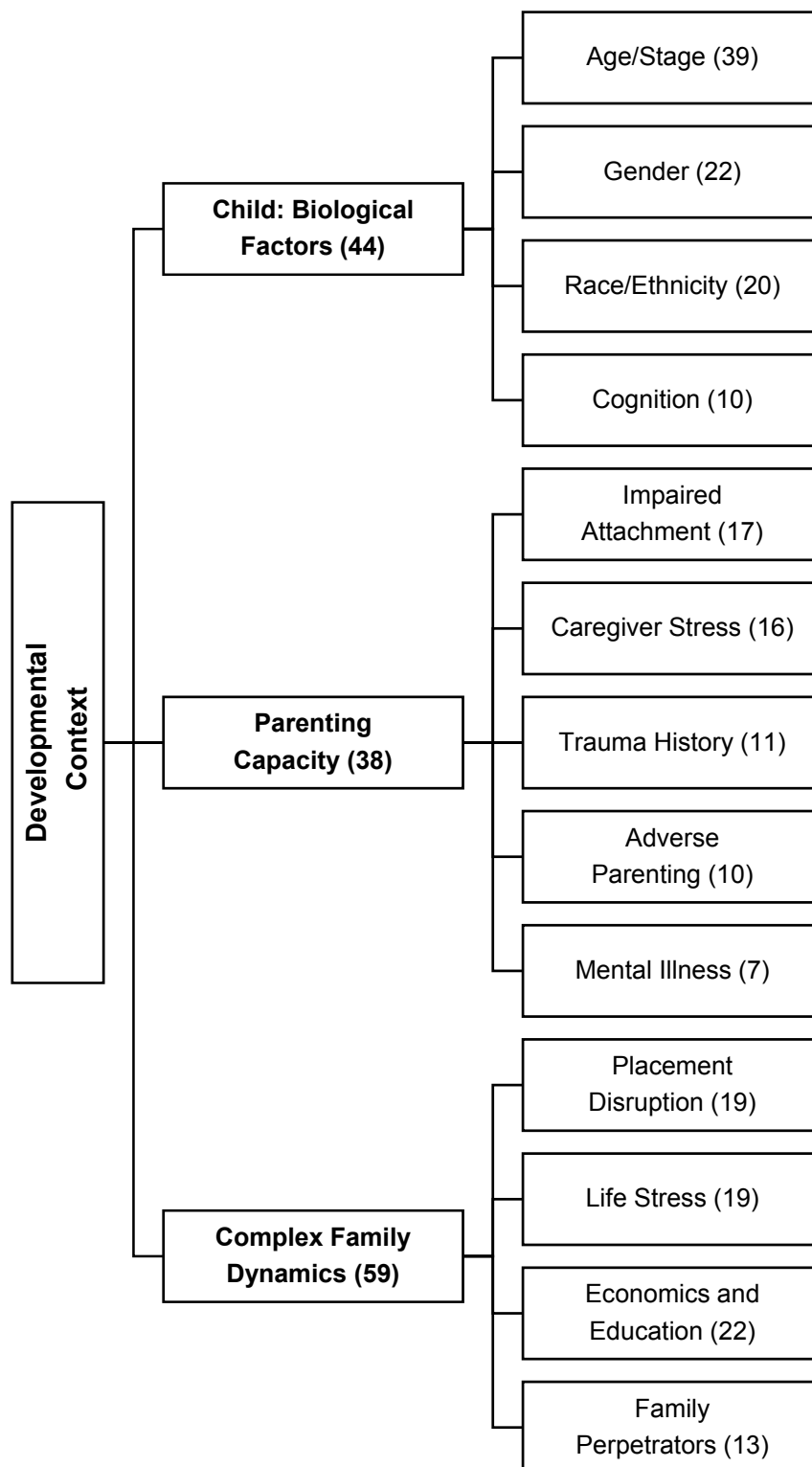


Figure 6. Developmental Context: Theme, sub-themes, and concepts.

Coded category: Age/Stage. Age/Stage is the label associated with the chronological *age* of a child and *stage* refers to the developmental stage of a child, which may differ depending on diverse biological and ecological variables. This code occurred 39 times in the data. The following examples show the relevance of age specific to child sexuality and sexual behavior problems.

Some researchers have suggested that this inverse relationship suggests that, at least to some degree, SBP are due to immaturity. (Friedrich et al., 2003, as cited in Elkovitch et al., 2009, p. 593)

Several additional factors modify the extent and nature of the child's sexual behavior: age of the child, developmental stage of the child, family environment, and parental behavior and response to the child. (Kellogg, 2009, p.993)

Child age has been the most widely investigated ontogenic factor relevant to the development of problematic sexual behavior following CSA (child sexual abuse). (Elkovitch et al., 2009, p. 591)

Sexual behavior showed an inverse relationship with age, with overall frequency peaking at year 5 for both boys and girls, and then dropping off over the next 7-years. (Friedrich et al., 1998, p. 6)

Older children are suggested to be more knowledgeable than younger children about sexual behavior, pregnancy, and sexual abuse prevention. (Gordon et al., 1990, as cited in Thigpen, 2009, p. 68)

Diverse biological, genetic, and environmental factors affect child development.

The data from this study suggests limited evidence exists to support an accurate contemporary interpretation of age and development in relation to child sexual development and maladaptive sexual behavior as suggested in the following examples.

To date, researchers have tended to study children with SBP in broad age ranges such that two or more distinct developmental stages are included whereby confounding any developmentally relevant information. (Elkovitch et al., 2009, p. 595)

The results also suggest that children of different ages engage in similar types of behaviors. These findings not only underscore the necessity of identifying contextual factors emanating from the child's environment that may explain

variance in sexual behavior but also ascertaining a child's motivation for engaging in behavior, as children at different stages of development are likely to be motivated for and experience sexual behaviors differently. (Thigpen, 2009, p. 78)

Consequently, careful consideration of a child's age and developmental stage are necessary when determining if a child's behavior is inappropriate or not.

Coded category: Gender. Gender is another biological factor related to child sexual behavior problems and child sexuality. Coding occurred 23 times from the data. Gender as reflected in the data, solely represented a binary system of male and female gender. Of note, there were no studies reflecting children who may identify outside the binary gender system such as children who identify as gender-neutral, transgender or intersex. Simply defined, *transgender* refers to the circumstance when a person feels that the gender assigned at birth, based upon their anatomy, does not accurately reflect the gender that is accurate for them (Transgender, 2013). The term, *intersex*, currently referred to as Disorder of Sexual Development, is a general term applied when a person is born with anatomy that does not fit the typical gender definitions of female or male ("Intersex," 2013). Consequently, results from this study only reflect children identified as either male or female.

Throughout the analysis of data, awareness of the scant literature and antiquity of results related to gender and childhood sexuality are important considerations in relation to the conceptualization of childhood sexual behavior and sexual behavior problems. Based on the results, there was some evidence from the data that gender may pose differences in a child's expression of sexuality and sexual behavior.

Both boys and girls demonstrate SBP, with the pattern of research suggesting a somewhat greater prevalence in girls during preschool years and in boys during school-age years. (St. Amand, Bard, & Silovsky, 2008, p. 146)

Young girls with SBP may be more responsive to environmental factors and reduce these problematic sexual behaviors once reaching school age. (Silovsky & Niec, 2002, p. 194)

Boys in the current study tended to display more external sexualized behavior, whereas girls showed more subtle, internalizing behaviors. (Merrick et al., 2008, p. 131)

Several gender-related behavioral patterns emerged. First, primary caregivers reported a narrower range of behavior for girls. (Thigpen, 2009, p. 71)

However, others found there was little difference in behavior related to gender.

Findings from the data suggest that gender variances might reflect differences between the sociocultural beliefs of adult males and adult females as noted in these examples.

Few gender differences in reliability were evident. (Friedrich et al., 2001, p. 42)

The literature, however, does not show pervasive gender differences in reported problematic sexual behaviors in samples of children from the community. (Elkovitch et al., 2009, p. 593)

Researchers have suggested that adults experience more anxiety over girls' displays of sexual behavior than boys, and that adult reactions inhibit the sexual expression of girls. It follows that the behavior of girls may be pathologized when it falls outside of cultural norms pertaining to appropriate gender role behavior. (Thigpen, 2009, p. 78)

Females tended to view many child sexual behaviors as more abnormal than did males. Historically in our culture, males have had more permission to be aware of their sexual needs and strivings and have had greater tolerance for a wider range of sexual activities. (Heiman et al., 1998, p. 299)

Ultimately, the question remains of whether reported gender differences were reflective of adult perceptions and sociocultural beliefs versus actual variance in sexual behavior due to gender.

Coded category: Cognition. Another associated factor related to child development and sexual behavior that emerged from the data, labeled Cognition, occurred 10 times in the coding process. Cognitive development, as previously

mentioned in the preliminary review of this study, is a significant component of human development. Simply stated cognitive development is the evolution of an individual's ability to think and comprehend. Recent theories on cognitive development expanded Piaget's work to include outcomes from biological and behavioral sciences. A wide consensus exists for overwhelming support that genetics interplay significantly at the earliest points of development with experiences from the environment that affect cognitive development (Carlson, Miller, Heth, Donohue, & Martin, 2010).

Although an important factor related to child development, few studies included assessment of cognitive abilities of children. Examples revealed in the data suggest that limited or delayed cognitive abilities may be associated with children exhibiting sexual behavior problems.

For children with sexual behavior problems, treatment must extend beyond the therapy suite. Many of the children in this research (42%) qualified for special education services. An additional 22% needed academic assistance in the form of compensatory education. (Gray et al., 1997, p. 287)

In their sample of preschoolers exhibiting extreme problematic sexual behavior, receptive language capabilities fell in the low average range. (Silovsky, 2002, as cited in Elkovitch et al., 2009, p 593)

Special education services were received by 59% (*N*-575) of the subjects in this research. (Gray, Pithers, Busconi, & Houchens, 1999, p. 610)

Children with sexual behavior problems exhibited a number of functional impairments commonly associated with maltreatment, including learning and psychiatric disorders. (Gray et al., 1999, p. 601)

Despite the significance of cognition on child development there was limited information specific to the interplay between a child's cognitive stage of development and sexual behavior. As previously mentioned, at times adult and adolescent cognitive attributes are attributed to children exhibiting sexual behaviors, in particular to the

motivations and intentions assigned to their sexual behaviors. The concept that children exhibit adult-like sexual behaviors with mature cognitive abilities appears unsupported in the data as noted in the following example.

Although children 12 and under are capable of empathy, they are more concrete thinkers than adults, and the level of expressed empathy is typically much less than would be expected for adults. Likewise, the level of planning required for “grooming” is beyond the cognitive abilities of most young children. (Swisher et al., 2008, p. 54)

Furthermore, there was an absence of information specific to the cognitive abilities of children identified with problematic sexual behavior. Limited results suggest that many children exhibiting sexual behavior problems have cognitive delays, learning disorders or functional impairments.

Coded category: Race /Ethnicity. The concept labeled Race/Ethnicity represents unique attributes of each individual. Race is a term that commonly refers to the features of an individual’s physical appearance such as skin tone, eye color and shape, jaw structure, hair color, etc. Race is also considered as a classification system used to categorize individuals into groups through diverse affiliations (Abizadeh, 2001). Ethnicity is terminology used to refer to cultural factors, like ancestry, nationality, language and beliefs shared by members who identify within a particular group (Blank, Dabady, & Citro, 2004). In some instances, the terms race and ethnicity are used interchangeably, and are constantly evolving (Abizadeh, 2001).

There appears to be consensus on the social construction of categories and terminology associated with race, rather than race being biologically defined (Abizadeh, 2001; Williams & Templeton, 2003). This seems true for ethnicity as well. According to Grosfoguel (2004), racial/ethnic identity is one concept and not considered as

autonomous or separate categories. Comprehension of the concepts of race and ethnicity in relation to human development and social construction are essential; yet exceed the limitations of this study. Yet, both are quite relevant to child development, sexuality, and sexual behaviors. For purposes of this study, the use of race and ethnicity will be as one concept.

The concept labeled Race/Ethnicity specifically drew attention to the gap in literature on childhood sexual behavior, particularly for persons who identify other than White and/or European American. There were only two peer-reviewed articles (Stanton et al., 1994; Thigpen, 2009) specifically related to child sexual behavior and non-White, African American children, identified in the data search. Only one (Thigpen, 2009) was included for review and analysis. The study completed by Stanton and colleagues (1994) was excluded as it was a blended study with results for preadolescent and adolescent participants, children 9 to 15 years-old, conducted prior to 1995.

Race/Ethnicity emerged from data 28 times during the coding process. Excerpts illustrate the gap and necessity for more research specific to the unique attributes of children and families from non-White populations. The majority of research conducted on childhood sexual behavior problems was based primarily on children identified as White, European Americans. Yet the results from such studies contribute to the social construction of understanding and conceptualization of what constitutes child sexual behavior that is normal, or maladaptive and problematic. Consider the implications of the lack of empirical knowledge related to variations of sexual development across ethnicity and race as illustrated in this quote from the data.

Given the influence of race and ethnicity on sexual behavior, the imposition of a normative standard of childhood sexual behavior derived from studies of White, middle-class children is potentially problematic. (Thigpen, 2009, p. 68)

For example, the CSBI (Friedrich, 1997), commonly used in empirical research and clinical assessment was normed on a large sample of 1,114 children across three regions in the United States of America, Canada, and Germany. This assessment tool had wide dissemination and use; for many years, it was the only empirical tool available to assess child sexual behaviors. The tool was normed on mainly White, European American children from lower and middle social economic class families, and data collected was adult-reported by female, maternal caregivers (Friedrich, 1997). Yet, results from research and clinical application of this tool, likely had considerable influence on the constructed beliefs related to child sexual behavior and problematic sexual behavior that extended to a diverse array of non-White children.

Because 20% of the non-abused sample (n =1/4 of 1114) on which the CSBI was standardized was characterized as non-White and low-income, the instrument is thought to be an appropriate measure for children from families of diverse social and economic backgrounds. (Thigpen, 2009, p. 69)

The category Race/Ethnicity highlights the limitations and potential detriment resulting from insufficient evidence and understanding of childhood sexual behavior and sexuality for non-White children and families. Reported variations of sexual behavior of African American children revealed discrepancies with studies on predominantly White children, as noted in the following quotes from the data.

African American children were reported to display a broad range of sexual behaviors. However, the prevalence of individual behaviors in the overall sample was low, and the sexual behaviors that were observed were reported to occur infrequently.... although African American children engaged in behavior that may be construed as sexual, sexual behavior was not elevated or pronounced among them. (Thigpen, 2009, p. 76)

A final implication stemming from patterns observed in the data involves the four items not observed by African American primary caregivers in the sample. These items were reflective of sexual intrusiveness that specifically involved requesting, planning, or forcing other children and adults into sexual activity. That these behaviors were not observed may indicate that these behaviors are beyond typical behavior for African American children. (Thigpen, 2009, p. 78)

The following quote effectively highlights long-standing stereotypes, biases, and racism, which further contribute to difficulties in collecting accurate data and information representative of ethnic and racial groups in the United States.

Thigpen, Pinkston, and Mayefsky (2003) documented and discussed the potential for mislabeling the sexual behavior of African American children in the absence of normative data, as well as the harmful effects of labeling. (Thigpen, 2009, p. 68)

West (2001) contended that sexuality has long been a taboo topic and issue both between African Americans and Whites, as well as within the African American community....In awareness of these fears, long-standing institutions within the African American community-primarily the church, family, schools-promoted sexual silence by condemning sexuality as a way to survive and as a means to attaining social acceptances. African Americans remain reluctant to discuss sexuality openly out of fear that discussions of this nature will confirm long-standing stereotypes. (Thigpen, 2009, p. 77)

Generalizing results from studies non-representative of non-White participants that portray limited understanding of childhood sexual behavior is risky, likely inaccurate, and may contribute to the damaging effects of stereotypes and labeling on non-White children and families.

Sub-theme: Parenting Capacity and related concepts. The American Psychological Association refers to parenting as the practice of providing health and safety for a child while preparing the child for a functional and productive adult life (Kazdin, 2000). Davies (2000) expanded the definition as child rearing aside from the biological relationship, one that promotes the physical, emotional, social, and intellectual

development of a child from infancy to adulthood. The role of parent is one considered critical to positive, healthy child development.

The sub-theme, Parenting Capacity, emerged throughout the coding and analytic process 40 times as a significant influence upon child development and sexual behavior. This sub-theme represents a caregiver in the role of parenting and their ability to function as a parent for an extended period. Conley (2003) differentiates capacity from the term ability; a caregiver's capability to parent effectively or 'good enough' over the long term defines parenting capacity. Various aspects of parenting are associated with parenting capacity, which include behaviors that enhance development across a range of situations supported by a positive parent-child relationship (Conley, 2003; Donald & Jureidini, 2004).

There are broad implications of Parenting Capacity related to childhood sexual behavior as suggested from the data. This sub-theme was highly associated with the sub-themes, Child: Biological Factors and Complex Family Dynamics. Child development and etiological factors linked from the data related to categories associated with Parenting Capacity. The related concepts include a) Impaired Attachment, b) Caregiver Stress, c) Trauma History, d) Adverse Parenting, and e) Mental Illness (as illustrated in Figure 6).

Coded category: Impaired Attachment. Impaired Attachment emerged 17 times during the coding process and was strongly associated with the sub-theme Parenting Capacity. Although there was no literature solely exploring the quality of the parent-child attachment relationship, the implication for the concept of Impaired Attachment in relation to childhood sexual behavior problems was evident from the results. Various

studies suggest evidence of impaired attachment among children with sexual behavior problems (Gray et al., 1999; Pithers et al., 1998; Silovsky & Niec, 2002). One study identified 4% of children exhibiting sexual behavior problems had the diagnosis of reactive attachment disorder (Gray, et al., 1997). The following sample excerpts from the data analysis, strongly infer the significance of the quality of attachment and the effect on the parent-child relationship.

Regardless of its etiology, the most common parental stance toward their children was rejection or, at best, an insecure attachment. (Waters, Posada, Crowell, & Keng, 1993, 1994, as cited in Pithers et al., 1998, p. 139)

Multiple disruptions in the parent-child relationship may place the child at risk for continued behavior problems and attachment difficulties. (Silovsky & Niec, 2002, p. 195)

In that study, parents viewed their children as possessing qualities that they considered disappointing or undesirable. They appraised their children as excessively demanding of their attention and time, distressed, and depressed. Parents found interactions with their children to be unrewarding. The parents were emotionally distant from their children. (Gray et al., 1999, p. 617)

An insecure or absent parent-child bond has long been believed to disrupt identification with both parental and societal values, resulting in impaired internal behavioral controls. (Elliott, Huizinga, & Ageton, 1985; Hirschi, 1969, as cited in Pithers et al., 1998, p. 139)

Other caregiving dimensions were also found to be important, such as the loss of a father and parent-child role reversal. Parent-child role reversal and pseudo maturity in the child point to a generalized lack of emotional support from caregivers, not just periodic negative verbalizations directed toward the child. (Hall et al., 1998, p. 1056)

In addition, sexualized behaviors may represent an effort to gain physical closeness and intimacy. Exhibiting sexualized behaviors in this sense may be somewhat adaptive for children, helping them to cope with trauma. (Gilgun, 2006, as cited in Merrick et al., 2008, p. 129)

Diverse factors may affect the caregiver's capacity to parent; these may include influences at home and within the family system, such as traumatic abuse (sexual or

otherwise), substance abuse, mental illness, and parenting styles (Friedrich et al., 1998, 2003; Letourneau et al., 2004, Lovejoy, Gracyk, O'Hara, & Neuman, 2000; Pithers et al., 1998). According to extant research, significant rates of high parental stress and environmental influences affect children exhibiting sexual behavior problems (St. Amand et al., 2008; Bonner et al., 1999; Friedrich et al., 2001; Pithers et al., 1998; Silovsky & Niec, 2002).

During the coding process in this study, Caregiver Stress emerged 16 times, Trauma History 11 times, Adverse Parenting 10 times, and Mental Illness emerged seven times. Although individually tagged during the coding process, these concepts were highly associated with one another. According to results, they collectively influence a caregiver's capacity to function in the role as parent. The following section elaborates on the related concept that emerged from the data.

Coded category: Caregiver Stress. Stress has been associated with disturbing the parent-child relationship, parenting style, and function of the caregiver within the family. High levels of distress specific to the parenting caregiver were associated with children exhibiting sexual behavior problems.

High levels of distress in the children and their caregivers were evident across a number of psychometric and historical variables. (Gray et al., 1999, p. 601)

The data clearly demonstrate that families of children with sexual behavior problem are marked by an array of characteristics indicative of parental and familial distress. (Gray et al., 1997, p. 267)

It is easy to imagine the psychological weight that parents must carry as they care for children with sexual behavior problems. (Pithers et al., 1998, p. 139)

Sexual behavior problems can be a source of anxiety to parents. (Hornor, 2004, p. 63)

Conversely, when parents have relatively few coping skills and are subjected to prolonged periods of high stress, days of heightened stress have shown to covary with disrupted maternal discipline, irritability, and increased frequency of behavior problems in their children. (Snyder, 1991; Wahler & Dumas, 1984, as cited in Pithers et al., 1998, p. 139)

Raising children with SBP is often stressful for the caregiver and may lead to dysfunctional adult-child interactions and disruptions in the child's residential placement. (Silovsky & Niec, 2002, p. 195)

Whether the distress occurred prior to or resulting from the child's sexual behavior is not clear from the literature; however, the data suggest there are diverse family dynamics that co-occur and directly affect the children exhibiting sexual behavior problems.

Coded categories: Trauma History and Mental Illness. Data suggest caregivers in studies related to child sexual behavior problems identified with histories of childhood and/or adult trauma, and mental illness. The implication of the concept Trauma History represents parenting caregivers exposed to trauma and abuse as children and/or as adults who experienced sexual assault, domestic violence, or other forms of trauma in adulthood. As may be anticipated, the concept labeled Mental Illness was associated with the related concept, Trauma History.

Mental illness, mental or psychiatric disorder, and psychiatric illness are terms commonly interchanged that represent socially constructed language reflecting differences depending on their application and interpretation. In this study, the term of Mental Illness reflects a combination of the following two definitions. The US Department of Health and Human Service, National Institute of Mental Health defines *mental illness* in the following manner.

Mental illness is defined as ‘collectively all diagnosable mental disorders’ or ‘health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. (US Department of Health and Human Services [USDHHS], National Institute of Mental Health [NIMH], 1999)

The definition expands with the following description of mental disorder from the

Diagnostic and Statistical Manual of Mental Disorders.

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotional regulation, or behavior that reflects dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. (American Psychiatric Association [APA], 2013, p. 20)

The relationship between the conceptual categories of Trauma History and Mental Illness, as related with childhood sexual behavior problems and the sub-theme Parenting Capacity are illustrated in these sample quotes from the data.

Significant psychopathology, including characterological problems and chemical dependency, has been reported in the parents of children with sexual behavior problems. (Pithers et al., 1998, as cited in Gray et al., 1999, p. 604)

The caregivers of children with interpersonal sexual behavior problems also appear to be trauma victims and show signs of ongoing disturbance; symptoms reported by these mothers appear to be interfering with parental functioning. (Hall et al., 1998, p. 1056)

There is also evidence that both mothers and children have difficulty maintaining appropriate protective boundaries for themselves and respecting the boundaries of others in nonsexual areas. (Hall et al., 1998, p. 1056)

As well, the high percentage of maternal caregivers who experienced multiple forms of childhood maltreatment and who exhibit chronic stress and PTSD symptoms point to the need to provide therapeutic assistance for the caregivers own issues. (Hall et al., 1998, p. 1059)

Many of the children in this research came from families with a multigenerational history of abuse. (Gray et al., 1997, p. 286)

According to the data, it seems the challenges of mental illness and trauma significantly influence a caregiver's parenting style and capacity to function in the role as a nurturing and protective parent (Lovejoy et al., 2000). Evidence from the data emerged as the category labeled Adverse Parenting that strongly associated with children who exhibit problematic sexual behaviors and other externalized behavior problems.

Coded category: Adverse Parenting. Adverse Parenting as a concept related to Parenting Capacity, occurred 10 times in the coding process and strongly related to the major theme Developmental – Ecological Context. The role of parenting adopted by the caregiver has significance upon the child's social-emotional and behavioral development. The concept Adverse Parenting refers to the lack of positive techniques and interactions conveyed from the primary caregiver toward a child. Adverse Parenting implies use of a broad range of parenting behaviors that may not be defined as abusive, but may be lacking in consistency, nurturing, or positivism. For example, adverse parenting practices may include poor supervision and monitoring, harsh, or coercive discipline, and the lack of nurturance (Donald & Jureidini, 2004; Patterson, 1982, 2002; Loeber & Stouthamer, 1986, as cited in Elkovitch, 2009). Sample excerpts from the data illustrate the concept of Adverse Parenting and the developmental and psychological effects on a child's development.

The concept of coercive parenting, characterized by rejection, neglect, poor supervision and modeling aggressive, threatening, or forceful interpersonal behaviors was suggested to influence disruptive behavior problems in children. (Patterson, DeGarmo, & Knutson, 2000, as cited in Friedrich et al., 2003, p. 97) Further overlap is found in the factors that contribute to the development and maintenance of both disruptive behavior problems and SBP (e.g., history of violence exposure, poor supervision/monitoring, negative parent-child relationship). (Burke, Loeber, & Birmaher, 2002; Friedrich et al., 2004, as cited in Silovsky et al., 2007, p. 380)

Extant literature and results imply the relationship between the child and primary caregiver significantly affects development across multiple domains (Donald & Jureidini, 2004). The parenting caregiver poses additional importance on the psychosocial, emotional, and behavioral development of the child. Findings posit that disruption in the caregiver's capacity to provide consistent, nurturing, stable support for a child, directly contributes to maladaptive and disturbing emotional, interpersonal, and behavioral problems (Donald & Jureidini, 2004). Such problems may include child sexual behavior problems. Results from the data illustrate the complexity of factors within the ecology of the family that influence the onset and maintenance of childhood sexual behavior problems.

Hall et al. (2002) found that children demonstrating the most severe SBP (those that were interpersonal in nature, planned, and coercive) received significantly less maternal support than those children demonstrating self-focused or developmentally expected sexual behaviors. (Elkovitch et al., 2009, p. 592)

The development of SBP appears to have multiple origins. Parenting practice, exposure of sexual material, absent or disrupted attachments, exposure to family violence, physical abuse, and the development of nonsexual behavior problems contribute to the development and maintenance of childhood SBP. (Friedrich, 2002; Friedrich, Davies, Fehrer, & Wright, 2003; Gray et al., 1999, as cited in Silovsky et al., 2007, p. 379)

Sub-theme: Complex Family Dynamics and related concepts. The third sub-theme, Complex Family Dynamics, encompassed within the major theme Developmental-Ecological Context, emerged from the results suggesting the family environment and parent-child relationship were highly influential of a child's sexual development and functioning. The sub-theme labeled Complex Family Dynamics occurred 59 times and was greatly associated with other related concepts of a) Placement Disruption, b) Life Stress, c) Economics and Education, and d) Family Perpetrators.

These emerging categories further illustrate the multiple origins of childhood sexual behavior problems evidenced from the coding and analysis process.

As previously noted, the relationship of the parent to the child in establishing trust, safety, and security are foundational to the child's overall health and well-being. Specific to the presenting issue of child sexual behavior problems, various experts have identified the significance of the caregiver and family on the child. Research has "repeatedly demonstrated that family and community contexts play a role in sexual development and the origins of child sexual behavior problems" (Silovsky & Letourneau, 2008, p. 108). The following excerpts from the data further highlight this point

Family values and behavior have a major impact on the development and expression of sexual behavior in children. (Friedrich et al., 1990, as cited in Gray et al., 1997, p. 271)

Several additional factors modify the extent and nature of the child's sexual behavior: age of the child, developmental stage of the child, family environment, and parental behavior and response to the child. (Kellogg, 2009, p. 993)

Third, familial variables seem to inhibit or potentiate problematic sexual behavior (sexual attitudes and interaction styles, violence and criminality, multiple maltreatment histories, and maintenance of appropriate parent-child roles). (Hall et al., 1998, p. 302)

Research conducted by Friedrich et al., 2003 examined various potentiating variables (i.e., family adversity, modeling of sexuality and coercion, and social-emotional behavior problems) that might affect children exhibiting sexual behavior that did not have a history of sexual abuse. Results support associations between child sexual behavior, immaturity, and reactivity related to age (Friedrich et al., 2003). Strong correlations identified between childhood sexual behaviors and diverse behavioral factors included, externalizing, and internalizing behaviors and posttraumatic stress disorder; as well as factors like adverse family dynamics, hostile parenting, inconsistent or avoidant

parenting, reactive caregivers and poor supervision of a child's safety may place children at greater risk (Friedrich et al., 2003).

Family adversity was a labeled component of a proposed model from Friedrich and colleagues (Friedrich et al., 2003) based on their findings pertaining to the prediction and development of child sexual behavior problems. Family adversity in their model comprised family income, marital status, maternal education and total life stress as variables associated with child sexual behavior problems (Friedrich et al., 2003). Specifically, family adversity was found to be one of the strongest predictors of sexually intrusive behaviors, over and above that of sexual abuse (Friedrich et al., 2003). Findings from the data further suggest there were more than one reason why children display behaviors identified as sexual and that sexual abuse is not the sole reason for children exhibiting problematic sexual behaviors.

Research has emphasized the etiology and maintenance of problematic sexual behaviors as including factors across a number of domains, including biological, familial, economic and cultural. (Friedrich et al, 2001, 2003, as cited in Elkovitch et al., 2009, p. 587)

Similarly, sexual abuse was not the primary predictor of sexually intrusive behaviors in preteens when physical abuse and witnessing domestic violence, family adversity, and child behavior factors were taken into account. (Merrick et al., 2008, p. 123)

As demonstrated with the current data, the elements are family adversity, modeling of coercion, modeling of sexuality, and a vulnerable/predisposed child substrate. (Friedrich et al., 2003, p. 103)

Coded category: Economics and Education. Another related concept labeled Economics and Education was coded from the data 22 times. Mothers were frequently associated as primary caregivers in extant research on children with sexual behavior problems. Therefore, maternal education and family income were two variables often

selected for study due to their documented relationship to child psychopathology (Graham, 1979, as cited in Elkovitch et al., 2009). Results from analysis suggest that poverty closely connects with multiple forms of child maltreatment (Elkovitch et al., 2009; Friedrich et al., 2003; Gray et al., 1999; Pithers et al., 1998). The data analysis supported this association with child sexual behavior problems in the following sample excerpts.

Poverty is confounded with a number of other familial risk factors, including stressful life events and parenting. (Elkovitch et al., 2009, p. 595)

Sexual behavior appeared to be directly and significantly related to maternal education as well as a maternal attitude about the normalcy of sexual behavior in children. Mothers with more years of education and who reported their belief that sexual feelings and behavior in children was normal, reported more sexual behavior. This observed relationship of reported sexual behavior to education and social class has been reported earlier. (Friedrich et al., 1998, p. 6)

Statistics indicate that the children at greatest risk for maladaptive outcomes are those who are young at the time of exposure to economic hardship and/or experience severe and chronic hardship. (Lynch et al., 1997, as cited in Elkovitch et al., 2009, p. 595)

Not surprising, challenges for caregivers such as trauma, mental illness, poverty, and minimal education that culminate in a marginal capacity to parent, often reflects varied elements of distress and high levels of life stress. This was evident from the data analysis and labeled as the category, Life Stress.

Coded category: Life Stress. Life Stress emerged from the data 19 times during the coding process. Life Stress signifies the concept of stress experienced within a family system that often represents complex dynamics that are acute, chronic and impair functioning individually and collectively as a family system, and may extend beyond the family. This concept as captured in the following quotes highlights the implications of Life Stress directly affecting children and their sexual behavior.

The intense and wide range of problems that these young children exhibited was quite striking. In addition to having a mean level of SBP at the 99th percentile on the Child Sexual Behavior Inventory (CSBI), the children had a complex array of other behavior and emotional symptoms and experienced multiple stressful events, including changes in caregivers and home placements. (Silovsky & Niec, 2002, p. 194)

Specifically, there is evidence that life stress is related to increased sexual behavior in children. (Friedrich et al., 1992, as cited in Friedrich et al., 2001, p. 39)

Nonspecific behavioral changes as previously described are a reaction to some form of stress in the child's life, and without a disclosure of sexual abuse from the child, cannot be assumed to be a result of sexual abuse. (Hornor, 2004, p. 63)

This is consistent with the finding that life stress in children is associated with many psychosocial and behavioral problems. (Compas, 1987, as cited in Elkovitch et al., 2009, p. 594)

The implication for Life Stress affecting children exhibiting sexual behaviors is significant to the conceptualization of the presenting problem and the risk and protective factors for consideration. Findings thus far strongly suggest that childhood sexual behavior and sexual behavior problems are complex and multidimensional. They exceed the sole explanation that sexual behaviors result from sexual victimization. Other related concepts emerged from the data that reflected additional stressors occurring within the immediate and extended family system. These concepts include Family Perpetrators, Placement Disruption, and Adverse Parenting, which all related highly to Life Stress.

Sexual behavior problems in children are significantly related to living in homes in which there is disruption because of poor health, criminal activity, or violence. The greater the number of life stresses – including parental battering, death, incarceration, or illness requiring hospitalization; deaths of other family members, and child illness requiring hospitalization – the greater the number and frequency of sexual behaviors observed in children. (Kellogg, 2009, p. 995)

Coded category: *Family Perpetrators*. Not surprising, another finding from the data was the prevalence of perpetrators and criminal activities of involved adults raising children. This code occurred in the data 14 times and was highly associated with Life Stress. Based from collected information, studies reported as many as 45% to 92% of families of children exhibiting problematic sexual behaviors had at least one perpetrator of sexual abuse as well as parental or sibling perpetrators (Gray et al., 1997, 1999; Hall et al, 2002). The data suggests that many children exhibiting sexual behaviors appear to be from families with a multigenerational history of trauma and abuse.

The children's families manifest many markers of chronic distress, including high rates of poverty, sexual abuse, and perpetration within the extended family, and arrest for criminal behaviors. (Gray et al., 1999, p. 602)

Coded category: *Placement Disruption*. A property of the sub-theme, Complex Family Dynamics, labeled Placement Disruption, occurred 19 times in the coding process and was highly associated with Life Stress in that it represents the action of a child removed from their primary residence by child welfare social workers or law enforcement, usually as a safety measure. Children exhibiting problematic sexual behaviors are at risk for separation and placement disruptions from their primary caregivers, from foster homes, and *kinship* or relative care (Bonner et al., 1999; Chaffin et al., 2008; Silovsky & Niec, 2002; Silovsky et al., 2007; Tarren-Sweeney, 2008).

Raising children with SBP is often stressful for the caregiver and may lead to dysfunctional adult-child interactions and disruptions in the child's residential placement. (Silovsky & Niec, 2002, p. 195)

These placement disruptions are particularly concerning for these children as extant literature indicates that children who experience either volatile or multiple changes in placement are particularly vulnerable to continued internalizing and externalizing symptomology. (Newton et al., 2000, as cited in Elkovitch et al., 2009, p. 589)

Research indicates that among children in kinship or foster care, placement stability affected the presence of SBP, further underscoring the complexity of the development of SBP. (Silovsky & Letourneau, 2008, p. 108)

Safety might be for the child's welfare due to complex family dynamics or as a safety precaution for other children in the residence. Regardless of the reason, the act of a child leaving their home, even if it was removal from a foster home or kinship care placement, results in significant stress for the child (Hall et al., 2002; Melton, 1990, as cited in Elkovitch et al., 2009).

Given the strong correlation between violent and abusive family environments and sexual behaviors in children, it is not surprising that children who live in such homes may present clinically with sexual behavior problems after they are placed with alternative caregivers or in foster care. Sexual behaviors in these children may precede placement but may not have presented clinically or may manifest for the first time while in placement as a result of stress, situational changes, or greater accessibility to other children who may participate in such behaviors. (Kellogg, 2009, p. 995)

As shown in the core themes Child Sexuality: Ecological Context and Developmental-Ecological Context, biological factors and the ecology of the parent and family are crucial to a child's social, emotional, interpersonal, and behavioral functioning. Analysis of the extant data specifically reveals diverse elements within the ecological context of child development and the family system that affect the onset and maintenance of problematic child sexual behaviors.

Core Theme-Complex Trauma

Complex Trauma is the third major theme which emerged early in analysis. This theme illustrates the significance of the co-occurring issues of a child's exposure to traumatic events combined with the impact of extended exposure within the caregiving system and primary social environments (Cook, Blaustein, Spinazzola, & Van der Kolk, 2003). Exposure to chronic distress and traumatic disturbances during a child's

developmental process affects immediate and long-term outcomes for the child. This form of chronic abuse and exposure to traumatic events may lead to subsequent trauma (Cook et al., 2003). The following is an example of the implications of trauma and child maltreatment as related to children exhibiting sexual behavior problems.

Multiple factors influence the development and maintenance of SBP, including: (a) sexual abuse; (b) physical abuse; (c) exposure to violence (e.g., domestic violence, community violence, etc.); (d) exposure to traumatic event(s); (e) exposure to sexualized material (e.g., in the media, adults in the home); (f) impulsivity and difficulty following rules; (g) poor coping skills (e.g., limited ability to communicate about feelings and thoughts that results in acting out); (h) inadequate supervision by caregivers; and (i) multiple placements/lack of a consistent caregiver. (Friedrich, 2002; Friedrich et al., 2003; Gray et al., 1999, as cited in Swisher et al., 2008, p. 52)

Current research and clinical experience suggest traumatic events affect children in various ways. Yet, according to the American Psychological Association, there is also evidence that single or limited episodes of a traumatic event can resolve relatively quickly and with limited effect on a child's overall development and functioning (2008). In relation to child trauma, the caregiver's capacity to support, protect, and nurture the child has a direct impact on how well the child resolves their traumatic experience (Cook et al., 2003, 2007).

Extant research indicated children who exhibit problematic sexual behaviors have a higher incidence of exposure to violence, familial adversity, sexual abuse and other forms of abuse or neglect (Friedrich, 2007; Friedrich et al., 1998; Friedrich et al., 2003; Gray et al., 1997; Silovsky et al., 2007). It appears these children may be experiencing chronic incidents of maltreatment and abuse rather than single episodes of trauma.

Complex trauma is a term that best defines this type of ongoing exposure to abuse and/or

neglect (Cook et al., 2003, 2007; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

The two sub-themes, Child Maltreatment & Trauma and Psychosocial Emotional Distress, and their related concept categories emerged from the coding and analysis of the data. Figure 7 provides illustrated details of the theme, sub-theme, and concepts with the numerical details associated with codes applied during analysis.

Sub-theme: Child Maltreatment and Trauma, and related concepts.

Specifically, Child Maltreatment and Trauma emerged early and throughout the coding and analysis process. Child Maltreatment and Trauma occurred 59 times and was highly associated with the second sub-theme within Complex Trauma labeled as Psychosocial Emotional Distress. The conceptual implications of the sub-theme, Child Maltreatment from the data, are consistent with the terminology of *child maltreatment*. This term describes various forms of child abuse (e.g., physical, sexual, and emotional abuse) and neglect. There is no universal adopted definition of “child abuse and neglect” as each state provides its own definition. The definition applied with this sub-theme, retrieved from the United States Department of Health and Human Services (USDHHS) Children’s Bureau, states the following.

Child abuse and neglect is defined as an act or failure to act by a parent, caregiver, or other person defined by state law that results in physical abuse, neglect, medical neglect, sexual abuse, emotional abuse, or presents an imminent risk of harm to a child. (Child Welfare Information Gateway, 2011, p. 1)

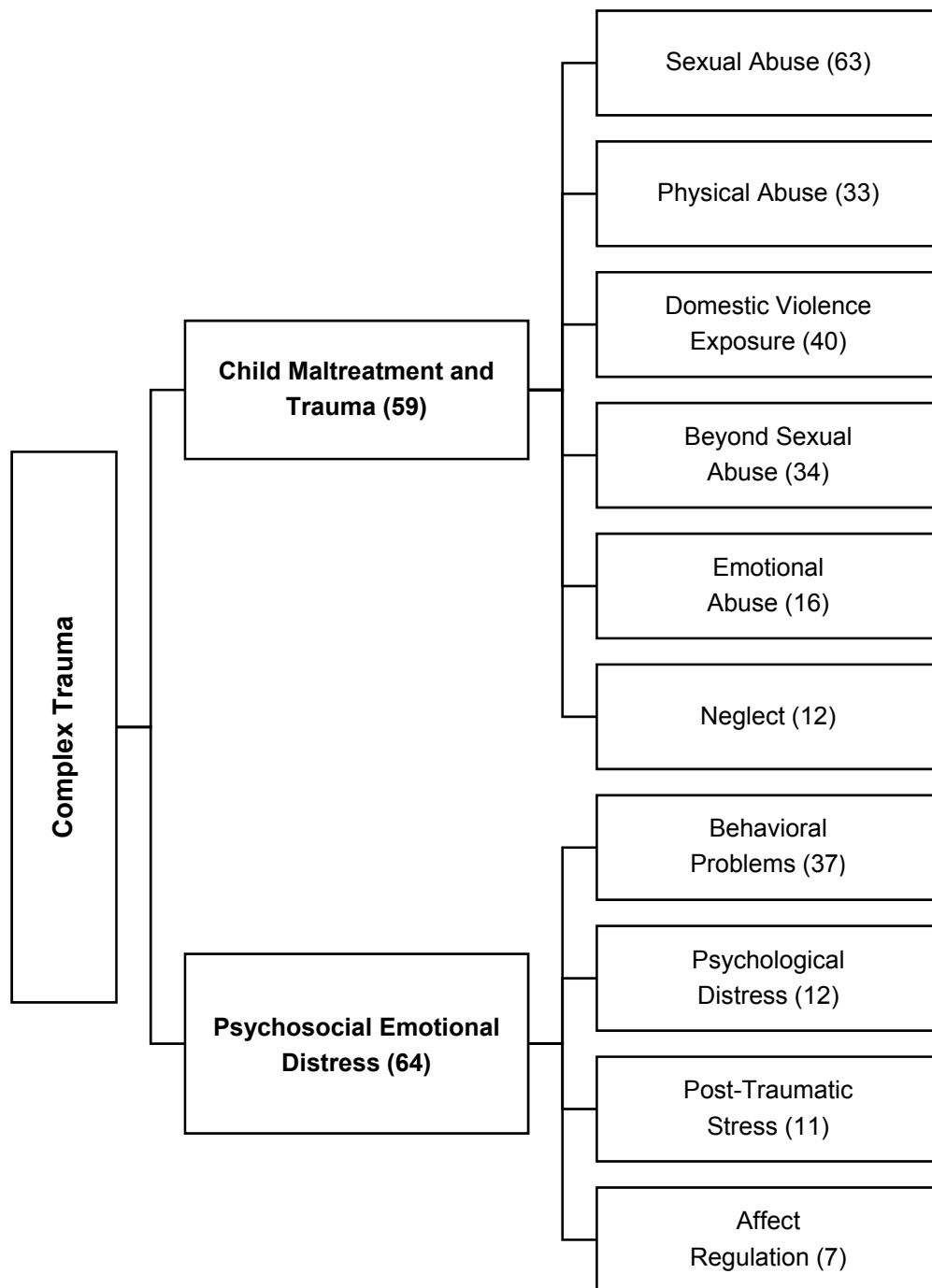


Figure 7. Complex Trauma: Theme, sub-themes, and concepts.

The conceptual categories related to the sub-theme Child Maltreatment and Trauma include a) Sexual Abuse, b) Physical Abuse, c) Domestic Violence Exposure, d) Beyond Sexual Abuse, e) Emotional Abuse, f) and Neglect. Coded concepts that emerged from the data suggest diverse forms of child maltreatment affect children exhibiting problematic sexual behaviors. The language related to the term Complex Trauma, as explained in the literature by Kagan (2004) refers to chronic occurrences of emotional abuse and neglect, sexual abuse, physical abuse, medical trauma, exposure to domestic violence, community violence, or war, which disrupts the child's security, stability, and primary attachments. Shared opinions from extant literature substantiate complex trauma significantly affects all domains of child development and functioning particularly self-regulation and management of basic life skills (Cook et al., 2007; Watts-English, Fortson, Gibler, Hooper, & De Bellis, 2006).

Coded category: Sexual Abuse. The concept labeled Sexual Abuse emerged 63 times during coding process. As discussed in the preliminary literature review of this study, early support from empirical studies suggested that "Empirical findings with sexually abused children indicate that sexual behavior is one of the more reliable and valid markers of sexual abuse" (Friedrich, 1995b, p. 1). At that time, other studies drew similar conclusions suggesting that sexually abused children had a higher incidence of sexual behaviors compared with non-abused children (Gale et al., 1988). Thus, early research perpetuated the belief that childhood sexual behavior was indicative of sexual victimization, as represented in these examples from the data.

Sexual victimization during childhood may be an etiological factor related to childhood sexual behavior problems. (Gray et al., 1997, p. 269)

However, behaviors that appear to resemble adult sexual activity, such as imitating or attempting vaginal or anal intercourse with another child, oral-genital contact, and French kissing, are observed in low frequency across all ages of children, and these behaviors occur more frequently in sexually abused children. (Friedrich, 1993; Heiman et al., 1998; Lindblad, Gustafsson, Larson, & Lundig, 1995; Larsson & Svedin, 2001, as cited in Hornor, 2004, p. 61)

Sexual behavior problems secondary to sexual abuse are associated with both cumulative distress and proneness to acting out. (Friedrich et al., 2003, p.97)

The following examples from the data reflect the preliminary conceptualization on the etiology of child sexual behavior problems, derived from early research that surmised sexual behavior problems were indicative of child sexual victimization.

Children who have been sexually abused have higher rates of SBP than children without such a history. (Friedrich et al., 1992, as cited in Silovsky & Niec, 2002, p. 187)

Still others have conceptualized SBP as reactions to sexual victimization and focused interventions on trauma sequelae. (J. E. Burton, L. A. Rasmussen, Bradshaw, Christopherson, & Huke, 1998, as cited in Carpentier et al., 2006, p. 483)

However, as research studies broadened with a wider lens, studies revealed child sexual behavior problems occurred due to various influences, as noted in these examples from the data.

When the results of his and others' research began to broaden conceptualization of the origins of SBP, Bill (Friedrich) responded by following the data. Whereas others then (and now) insisted that children with SBPs must have been sexually abused. (Silovsky & Letourneau, 2008, p. 107)

The finding of a relatively low frequency of a history of substantiated sexual abuse was unexpected. Only 38% had a substantiated sexual abuse history. (Silovsky & Niec, 2002, p. 194)

A common misunderstanding is that all children with SBP have been sexually abused. However, research indicates that many children with SBP have no known history of sexual abuse. (Bonner et al., 1999; Johnson, 1988; Silovsky & Niec, 2002, as cited in Swisher et al., 2008, p. 52)

By the 21st century, various studies revealed that although child victims of sexual abuse may exhibit more sexual behavior than non-abused children, sexual behavior was not considered diagnostic of child sexual abuse as once thought. (Chaffin et al., 2008; Friedrich et al., 2001, 2003; Shaw, 2000)

Coded category: Beyond Sexual Abuse. Data coded and analyzed in this study revealed findings that supported the category, Beyond Sexual Abuse. Data emerged 34 times as Beyond Sexual Abuse in the coding process. Results reflected a shifting landscape of understanding related to children exhibiting problematic sexual behaviors. Results from extant studies indicated that sexual behavior in children correlated to a multiplicity of ecological factors such as, the child's age, maternal education, family sexuality, family stress, family violence, and hours/week in day care (Friedrich et al., 1998).

One study by Gray and colleagues (1997) indicated over 62% of children exhibiting problematic sexual behaviors had exposure to family violence. Access to sexually explicit content, lack of parental involvement and neglect of a child, were contributing factors of childhood sexual behavior problems (Friedrich, 2007; Friedrich et al., 1998; Friedrich et al., 2003; Gray et al., 1997; Silovsky et al., 2007). The following excerpts from the data further suggest strong evidence to support multiple origins for the onset and recurrence of child sexual behavior.

Bill found that children who have been sexually abused do demonstrate increased rates of SBPs, but that children with other types of trauma do as well. (Silovsky & Letourneau, 2008, p. 107)

Similarly, sexual abuse was not the primary predictor of sexually intrusive behaviors in preteens when physical abuse and witnessing domestic violence, family adversity, and child behavior factors were taken into account. (Friedrich et al., 2003, as cited in Merrick et al., 2008, p. 123)

Sexual abuse is a common, but not exclusive, experience among children with sexual behavior problems. (Kellogg, 2009, p. 997)

This is a major strength because it is essential to consider alternate explanations for sexualized behaviors rather than simply assuming a sexual abuse history if effective intervention programming for maltreated children is to be implemented. (Merrick et al., 2008, p. 130)

Ultimately, although there is support in the literature that children who have been sexually abused may display more frequent sexual behaviors than non-sexually abused children may; there is also significant support from empirical findings that children exhibit sexual behaviors for a multiplicity of reasons.

Coded categories: Physical Abuse and Exposure to Domestic Violence. These coded categories were highly associated with the sub-theme Child Maltreatment and Trauma. The concept Physical Abuse was coded 33 times and Domestic Violence Exposure occurred 40 times.

The following excerpts illustrate the relationship between the concepts, Physical Abuse and Exposure to Domestic Violence, as related to child sexual behavior problems. Specifically, the data coded and analyzed highlighted support that exposure to violence was a form of child maltreatment that correlated with child sexual behavior problems.

A substantial portion of this sample 25 (68%) was exposed to interpersonal violence. The relationship between exposure to violence and problematic sexualized behaviors in young children remains unclear but may result from a combination of trauma experiences with exposure to sexualized materials. (Silovsky & Niec, 2002, p. 195)

As many as 68% of children with sexual behavior problems have witnessed intimate partner violence among their caregivers. Adult violence in the home is strongly linked to abuse, neglect, and sexual behavior of children. (Kellogg, 2009, p. 995)

Findings from the literature revealed that children who experienced abuse or trauma exposure, including physical abuse and domestic violence, display increased rates

of sexual behaviors; exposure to violence had a stronger association with the presence of sexual behavior problems than sexual abuse (Friedrich et al., 2003).

It was evident from the co-occurrence of the related concepts that there was a strong association between diverse forms of child maltreatment with child sexual behavior problems. Data revealed that children exhibiting sexual behavior problems frequently had experienced multiple forms of maltreatment and multiple forms of trauma.

These risk factors (as related to emergence of sexually intrusive behavior) include aspects of the child's abuse experience, (e.g. sadistic, eroticizing, enacted by multiple perpetrators), as well as characteristics of the child, (e.g., sense of hopelessness, general boundary problems, sexually focused), the child's history, (e.g., frequent moves, physical abuse), the parent-child relationship, (e.g., sexualized, intrusive), and caregiver characteristics, (e.g., PTSD in the mother, attachment problems in the mother's history). (Friedrich et al., 2003, p. 96)

Coded categories: Emotional Abuse and Neglect. Emotional Abuse was coded 16 times and Neglect emerged more than 12 times from the data during the coding process. Although individually coded, all of the concepts related to the sub-theme Child Maltreatment and Trauma, frequently co-occurred from the data, as illustrated in the following sample excerpts.

Consistent with research indicating there is substantial overlap in maltreatment types (U.S. Department of Health and Human Services, 2005); many children exhibiting SBP experience multiple forms of maltreatment. (Elkovitch et al., 2009, p. 594)

Furthermore, maltreatment is often a marker of family characteristics related to increased exposure to sexuality (e.g., family nudity, poor boundaries, family chaos), and a marker of less effective socialization of children regarding a number of societal rules. (Friedrich, 1997, as cited in Merrick et al., 2008 p. 129)

Children demonstrating interpersonal problematic sexual behaviors (defined by the authors as “sexual contact/touch with others”) were significantly more likely than children demonstrating more normative sexual behaviors to have histories of physical and emotional abuse. (Hall et al., 1998a, 1998b) and to have been exposed to domestic violence and sexualized interactions in the home (Hall et al., 2002, as cited in Elkovitch et al., 2009, p. 592)

Neglect is a term defined by each state and depending upon the sociopolitical system utilizing the definition it may vary. For purposes of this study, neglect as reported by the USDHHS Children's Bureau Office on Child Abuse and Neglect (Child Welfare Information Gateway, 2006) describes neglect occurring when a parent or caregiver does not provide for a child's needs according to their age and stage of development. Neglect may indicate the lack of basic needs like food, shelter, and clothing for a child, and may include the absence of education, medical or mental health services (Child Welfare Information Gateway, 2006). Neglect also includes exposing a child to unsafe and violent events, poor supervision, and abandonment. A child deprived of emotional support and nurturance might also be deemed neglected, but this alone would not necessarily rise to a level of neglect that warranted legal or social service interventions despite the long term potential damage to the child and their development (Child Welfare Information Gateway, 2006).

Data and analysis suggested the concept Neglect linked to child sexual behavior problems, as well as, often was associated with other forms of maltreatment and trauma exposure. The following illustrates this from the data.

Neglect has also been associated with sexual behaviors in children. . . . In addition, indiscriminate affection-seeking and interpersonal boundary problems have been reported in children who are victims of neglect; such behaviors are often manifestations of attachment disorders seen in abused and neglected children. (Kellogg, 2009, p. 995)

Neglect, considered the most common form of child maltreatment in the United States often goes underreported and unacknowledged compared to other forms of child abuse (Child Welfare Information Gateway, 2006). This has been attributed to the fact that sexual and physical abuse often leaves scars, injuries and evidence of the abuse, whereas the impact of neglect often goes visibly unnoticed (Child Welfare Information

Gateway, 2006). Some studies have demonstrated evidence suggesting neglect may be more damaging and detrimental to a child's brain maturation and developmental process than physical or sexual abuse (Garbarino & Collins, 1999).

Sub-theme: Psychosocial Emotional Distress and related concepts. The sub-theme Psychosocial Emotional Distress, associated with the major theme, Complex Trauma, emerged during the data coding process 58 times. The four categories related to Psychosocial Emotional Distress include a) Behavioral Problems, b) Psychological Distress, c) Post Traumatic Stress, and e) Affect Regulation. Some codes emerged early and frequently during the coding and analysis process, while others were coded only a handful of times. Figure 7 illustrates the numerical details of associated codes with themes and sub-themes that emerged from the data.

Existing literature describes child trauma that reoccurs during formative years of development, as *complex trauma*, sometimes known as developmental trauma. Complex trauma, described as ongoing exposure to traumatic events, as related to children may evidence impairment in attachment, biology, affect regulation, dissociation, behavioral control, cognition, and self-concept (Cook et al., 2003). The consequences may be devastating for a child. Complex trauma typically interferes with formation of a secure attachment bond between a child and the primary caregiver, interfering with the child's principal source of stability and safety resulting in mistrust, insecurity and a lack of protection in the child's life (Cook et al., 2003, 2007).

Trauma affects the neurological, cognitive, and social-emotional functioning of children (Watts-English et al., 2006). Activation of the physiological response of the acute stress system from trauma exposure has widespread implications. Research

suggests there are significant adverse effects of stress associated with child maltreatment, affecting regulation of the neurobiological stress systems, alterations in brain maturation, and neuropsychological outcomes in a developing child (Gabowitz, Zucker, & Cook, 2008; Richert, Carrion, Karchemskity, & Reiss, 2006; Watts-English et al., 2006; Weber & Reynolds, 2004). Specifically, these significantly influence arousal, stress reactions, physical and cognitive development, brain development and affect regulation, which is the capacity to modulate and regulate emotional responses in a range of situations (Beers & De Bellis, 2002; Watts-English et al., 2006).

Coded category: Affect Regulation. Findings illustrate the influence of multiple forms of trauma affecting child development in various ways. Some traumatized children may exhibit sexual behaviors as a mechanism for interaction, emotional regulation, and connection. Affect Regulation emerged over seven times during the coding process. The following examples illustrate this concept.

Those children who learn how to regulate their behaviors and emotions can extend these skills to sexual behaviors. Children who have problems with self-regulation are those who exhibit externalizing behaviors, one of which is sexual behavior. Young children will have the greatest problems with self-regulation, and this may be one reason why parental report of general behavior problems was reported with sexual behavior problems. (Friedrich & Trane, 2002, p. 245)

It could be the case that later emotional abuse leads to various self-soothing behaviors. As for many maltreated children, sometimes these self-soothing behaviors are not normative and are instead manifested as maladaptive behaviors, such as certain sexualized behaviors. (Merrick et al., 2008, p. 130)

In addition, sexualized behaviors may represent an effort to gain physical closeness and intimacy. Exhibiting sexualized behaviors in this sense may be somewhat adaptive for children, helping them to cope with trauma. (Gilgun, 2006, as cited in Merrick et al., 2008, p. 129)

Children affected by trauma are subject to feeling overwhelmed by everyday challenges and coping capacities due to the effects of traumatic stress. These might

include, persistent re-experiencing of the event, persistent avoidance of situations associated with the trauma, and/or numbing of general responsiveness and physiological arousal (Gilgun, 2007). As noted, complex trauma significantly effects child development in areas such as affect regulation, inhibition, sustained attention, problem solving, abstract thinking, executive functioning, poor impulse control, and disorganization (Beers & De Bellis, 2002). The association between trauma and problematic childhood sexual behaviors seems evident as children affected by abuse, neglect, exposure to violence and other various traumatic events display an array of behavioral, emotional, social, interpersonal and psychological challenges (Chromy, 2007; Cook et al., 2003, 2007; Kagan, 2004).

Coded categories: Behavioral Problems and Psychological Distress. The implications of the association of the categories Behavioral Problems and Psychological Distress with child sexual behavior problems were evident from the data as concepts emerged during the coding and analysis process. Behavioral Problems emerged 37 times and Psychological Distress emerged 12 times during coding.

Children who have greater life stress, exposed to aggression, and unpredictability, were found more likely to have problems modulating behaviors of all types, including sexual behaviors (Chromy, 2007; Cook et al., 2003, 2007). Specific outcomes reviewed from one study, by Silovsky and Niec (2002), found that 89% of children with sexual behavior problems evidenced borderline-clinical range problems for externalized behaviors and 53% were in the borderline-clinical range for internalized behavior problems. Other examples of data associated with the concept of Behavioral Problems as related to children exhibiting problematic sexual behavior follow.

In a clinical sample of 127 children aged 6 to 12 with sexual behavior problems, 96% had additional psychiatric diagnoses. The most common diagnosis was conduct disorder (76%), followed by attention-deficit/hyperactivity disorder (40%) and oppositional defiant disorder (27%); most of the children in this sample had more than one psychiatric diagnosis. (Kellogg, 2009, p. 995)

It still comes as a surprise to many parents and clinicians, for example, that domestic violence and physical abuse are related to increased sexual behavior, as well as other behavior problems in young children. (Friedrich & Trane, 2002, p. 244)

Psychological Distress encompassed the conditions of emotional disturbance and, sometimes, psychological disorders associated with children who exhibit sexual behavior problems evident from the data. The following examples from the data analysis point to the connection between the related concepts, and child sexual behavior problems, encompassed within the major theme, Complex Trauma.

Co-occurring clinical issues can include other non-sexual behavior problems, mood disorders, trauma-related symptoms, and learning difficulties. (Swisher et al., 2008, p. 53)

In fact, sexual behavior was related to family variables that have been found to be empirically related to psychological distress in children. (Friedrich et al., 2001, p. 46)

Results reveal sexual behavior occurs among children with a sexual abuse history and children without. Consistent findings imply some form of maltreatment, or trauma, which often included complex family dynamics affecting developmental and coping capacities, impacted children who exhibit problematic sexual behaviors. Addressing childhood sexual behavior concerns and problematic sexual behaviors from a broadened perspective, one that encompasses complex trauma, maltreatment and the ecology of the family is relevant for conceptualization of the origins and influences related to this behavioral concern.

Core Theme-Ecological Interventions

Identifying and understanding the available options for effective interventions, treatment and assessment related to children with sexual behavior problems is essential for comprehending a current conceptualization of this issue. Two sub-themes highly associated with Ecological Interventions, were Effective Treatment, which occurred 102 times during coding and analysis, while sub-theme Clinical Assessment emerged 32 times. The core theme Ecological Interventions, with related sub-themes and concepts, illustrated in Figure 8, includes the associated numeric value of assigned codes.

Sub-theme: Effective Treatment and related concepts. Coded concepts related to the sub-theme of Effective Treatment include a) Cognitive Behavior Therapy, b) Parent Training and Education, c) Family Services, d) Supervision and Safety, e) Social Support Systems, and f) Individualized Treatment.

Many concerns related to child sexual behavior problems derived from the belief that such behaviors were difficult to treat and required specialized treatment or a residential treatment program. Contrary to such beliefs, evidence from current research suggests options for effective and successful treatment interventions applicable in outpatient, non-specialized clinical settings. The following sample quotes from the data highlight current findings that treatment for child sexual behavior problems yields successful outcomes, and differs from treatment for adults or adolescent offenders.

Available research suggests that with completion of appropriate treatment, children with SBP are at a very low risk for having further problematic sexual behavior. (Swisher et al., 2008, p. 60)

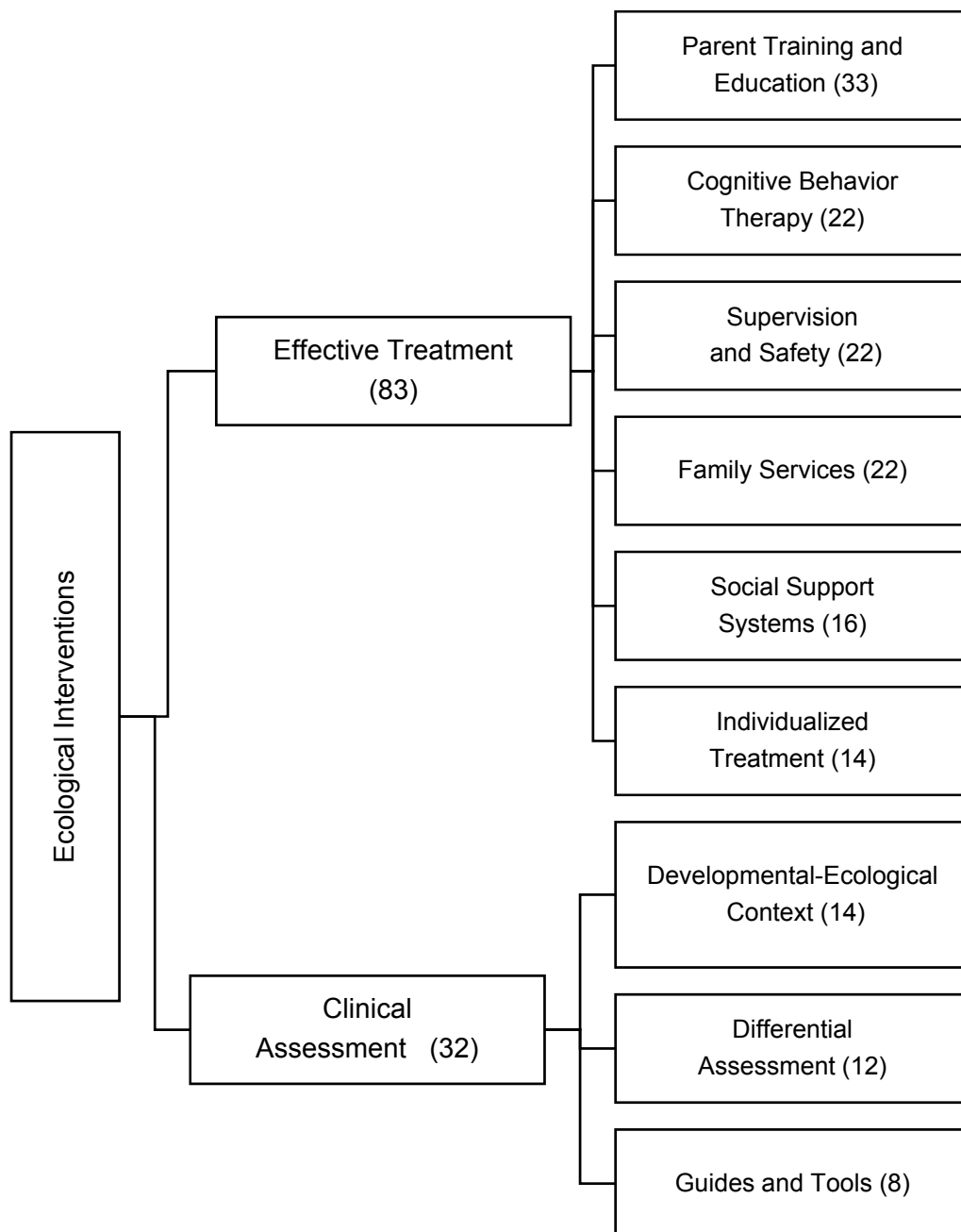


Figure 8. Ecological Interventions: Theme, sub-themes, and concepts.

Effective treatment for children with SBP should be distinguished from CBT approaches used to treat adolescent and adult sexual offenders...Treatment models bearing positive outcomes for children are not adaptations of adult or juvenile sex offender treatments; rather they are models designed specifically for children and their caregivers. (Swisher et al., 2008, p. 54)

After receiving short-term CBT, children's long-term risk for sex offense arrests or reports was not only significantly less than children receiving play therapy but was reduced to baseline, general-clinic population levels that are so low that they would be difficult to lower further. This finding is at odds with assumptions that these children pose an unusually, high and difficult to manage risk for becoming future adolescent or adult sex offenders or that they require long-term, intensive, or highly restrictive treatments to reduce that risk. (Carpentier et al., 2006, p. 486)

Specific aspects of various intervention models emerged as concepts coded from the data. The recurrent components highly associated with Effective Treatment were Parent Training and Education, 33 times, and the concept Cognitive Behavior Therapy was coded 22 times from the selected source articles. Other concepts that emerged were Family Services, coded 22 times, Supervision & Support coded 20 times, and Social Support Systems emerged 16 times from the coding process. Although individually coded, related concepts frequently co-occurred from the data. The sub-theme Clinical Assessment, strongly associated with Effective Treatment and other related concepts, is described later in this chapter.

Coded category: Cognitive Behavior Therapy. Although limited, extant literature has revealed positive outcomes for treatment of children with sexual behavior problems. A variety of treatment methods for children exhibiting sexual behavior problems have been implemented in research and clinical settings that suggest successful outcomes for preschool and school-age children (Bonner et al., 1999; Carpentier et al., 2006; Chaffin et al., 2008; Pithers et al., 1998; Silovsky et al., 2007). Specifically, CBT appears to demonstrate effective treatment outcomes for children. The following sample

quotes from the data illustrate the related category labeled, Cognitive Behavior Therapy, in relation to the theme, Ecological Interventions.

First, the findings support the use of short-term, focused, educative CBT for children with SBP and their caregivers. Second, the findings dispute the assumption that a large proportion of children with SBP are destined to grow up to become adolescent or adult sex offenders. Children with SBP who were provided with short-term CBT had future sex offense rates that were both very low in absolute terms but moreover were indistinguishable from those of a comparison group of clinic children with common nonsexual behavior problems such as ADHD. (Carpentier et al., 2006, p. 486)

Most children with SBP can be successfully treated with relatively short-term (3-6 months) treatment on an outpatient basis unless there are serious safety concerns about other children in the home. (Swisher et al., 2008, p. 55)

Specifically, as referenced in the above quoted example, one randomized trial comparing CBT and Play Therapy (PT) treatment for children involved in a ten-year follow-up study, found that children treated in CBT groups had significantly lower sex offense arrests or reports than those treated in play therapy groups, 2% vs. 10% respectively (Carpentier et al., 2006).

Another recent study noted the effectiveness of CBT for very young children enrolled in a CBT group. Silovsky and colleagues (2007) conducted a pilot study consisting of a 12-week group CBT treatment program for preschool children exhibiting sexual behavior problems, co-occurring trauma symptoms, and disruptive behaviors. Following treatment, results indicated significant reduction in problematic sexual behaviors. The following excerpt from the data highlights the positive outcomes related to application of CBT for treatment of child sexual behavior problems, as well as, for other co-occurring emotional and behavioral problems.

Drawing from the existent literature, several factors emerge as important for treatment for preschool children with SBP. Treatment needs to (a) directly address SBP using behavioral, CBT, and psycho-educational approaches; (b)

address the child's social problems, impulse-control, coping strategies, boundary issues, and caregiver-child relationship; (c) directly involve the parent/caregiver in treatment; and (d) include a behavior management training component. The treatment must be broad enough to address the needs of children with SBP who do not have a history of sexual abuse. (Silovsky et al., 2007, p. 380)

Silovsky and colleagues (2007) recognized the relevant value for the involvement of the caregiver in treatment with the child. The treatment format in the pilot study included simultaneous CBT treatment groups for children and their caregivers. Each group followed a teaching – learning model that was highly structured. The model applied CBT components such as behavior modification, psycho-education, relaxation, and stress reduction (Silovsky et al., 2007). Children learned self-control, self-regulation, and affect modulation. Caregivers learned child behavior- management skills, supervision, and coaching for enhancing the caregiver-child relationship (Silovsky et al., 2007).

Coded categories: Parent Training and Education; Supervision and Safety

Results from the coding and analysis of the literature revealed diverse inclusion of psycho-education, skills training and therapy support services for caregivers as strongly associated with effective outcomes from treatment. The concepts, Parent Training and Education and Supervision and Safety were highly associated with Cognitive Behavior Therapy. Parent Training and Education emerged 33 times during coding and was highly associated with treatment effectiveness for childhood sexual behavior problems.

Examples from the data illustrate the significance of Parent Training and Education in relation to the sub-theme, Effective Treatment.

Practice elements for parents, particularly behavioral parent training, were among the factors most strongly predictive of positive SBP outcome. (Silovsky & Letourneau, 2008, p. 108)

The findings suggest that children with SBP (including aggressive sexual behaviors) can be treated effectively with relatively short-term, outpatient approaches that have active caregiver participation in treatment and address behavior parent training, rules about sexual behavior, sex education, and abuse prevention. (Swisher et al., 2008, p. 55)

Part of the CBT treatment involved educating caregivers about the need for supervision and limiting opportunities in which SBP might occur. (Carpentier et al., 2006, p. 487)

Effective treatment requires caregiver involvement that addresses behavioral management training, rules about sexual behavior, sex education, supervision, and abuse prevention skills. (Swisher et al., 2008, p. 60)

Specific parent training and education topics for treatment included effective behavior management strategies, relationship building skills, praise, and reinforcement with younger children, and logical and natural consequences with older children (Carpentier et al., 2006; Silovsky et al., 2007; St. Amand et al., 2008).

Elements of safety for a child and other children in the home involve coordination of safety planning and support for the parent, specifically targeting supervision. The concept named Supervision & Safety coded 22 times was strongly associated with Effective Treatment. Quotes from the analyzed data, include examples of suggested supervision strategies as noted here.

After sexual behavior problems are recognized, environment and supervision changes may immediately occur (prior to the initiation of treatment) and may be required by CPS. (Silovsky et al., 2007, p. 338)

Reinforce with parents the importance of supervising the amount and content of media to which their children are exposed. (Hornor, 2004, p. 61)
When a neglectful or chaotic family environment is present, interventions focused on creating and maintaining a safe and stable environment should also be considered. (Chaffin et al., 2008, as cited in Swisher et al., 2008, p. 55)

Management of children with sexual behavior problems may entail a degree of environmental engineering...treatment must focus on training caregivers to identify and respond effectively to sexual abuse risks in the home. (Gray et al., 1997, p. 287)

With appropriate caregiver supervision, safety planning, and effective outpatient therapy, many children with SBP can remain in their home or a foster home with other children without problematic sexual behavior. (Swisher et al., 2008, p. 57)

In some cases, due to risk factors in the home where safety is a concern for the child exhibiting sexual behavior, or due to other children in the home being at risk for involvement with the child acting out, removal of a child from the home may be a necessary step toward establishing safety and appropriate interventions and services. Current literature suggests the least restrictive and disruptive options for placement need considered when removal from the home is necessary, such as living with a relative or in short-term foster care (Chaffin et al., 2008). Consideration for safety planning, education and training for the temporary caregiver is essential for the child and new caregiver's benefit. This excerpt for the data highlights this point.

In these cases, it is helpful to provide the new caregivers information about all of the child's needs and problems, including SBP, before the child is placed. Alternative caregivers should be given information on how to appropriately supervise children with SBP and should participate in SBP therapy with the child. (Chaffin et al., 2008, as cited in Swisher et al., 2008, p. 58)

Additionally, consideration for child reunification back into the family residence involves continued support and therapeutic interventions and services for the child and family. Data supports this point in the following quote.

If it is determined that reunification is appropriate, it is preferable to reunify children back into the home gradually and while they are still in treatment Treatment for children should continue after the children are returned home. This will provide the support for all of the family members during the adjustment period. Continued treatment also allows for continued monitoring of the safety plan implemented by the family and assistance with any modifications that may need to be made to the original safety plan. (Swisher et al., 2008, p. 59)

The necessity for treatment and family services, which support the well-being of the caregivers and family, as well as the child, seems essential due to the influences of the ecology of the family and parent-child relationship in the development and functioning of the child. The category, Family Services, emerged from the data 22 times during coding and analysis.

Coded category: Family Services. Findings previously discussed, strongly support the relationship between childhood sexual behavior problems, complex family dynamics and complex trauma. Results from the data and analysis suggest conceptualization of child sexual behavior problems as a family problem rather than as the pathological behavior problem of the child as suggested in the following sample quotes.

Changing the pattern of a child's sexual behaviors involves changing the child's social environment, rather than changing the child's thought processes. (Swisher et al., 2008, p. 56)

Thus, it is beneficial to courts to conceptualize these children as in need of family services and not as sexual predators, sexual offenders, or perpetrators. (Swisher et al., 2008, p. 60)

The results emphasize that the primary agent of change for SBP appears to be the parent or caregiver. (St. Amand et al., 2008, p. 161)

Thus, the effectiveness of treatment focused only on the individual child and their behaviors rather than the family may be incomplete. Data further indicated that successful outcomes for children necessitate that caregiver involvement and family-directed services need equal, if not greater, emphasis than individual interventions.

Although the concept Family Services emerged less frequently than Parent Education & Training, the category emerged from multiple data sets and was strongly

linked to the sub-theme Effective Treatment. The following quotes highlight the implication of parental involvement with family services in treatment with children who display sexual behavior problems.

One consistency across all SBP interventions has been the direct involvement of the caregivers in the treatment. (Silovsky et al., 2007, p. 379)

The importance of family and caregiving variables suggests that treatment efforts with children with sexual behavior problems should also include the family whenever possible. (Hall et al., 1998, p. 1059)

The practice elements found most effective to reduce SBP are caregiver-focused. (Swisher et al., 2008, p. 56)

Reducing the SBP, reducing caregiver stress, and improving the quality of the child-caregiver relationship may in turn improve the stability of the child's placement and make a significant impact on the child's long-term adjustment and social relationships. (Silovsky & Niec, 2002, p. 194)

The impact of behavior parent training alone is unknown, but clearly direct involvement of caregivers in the treatment of children with SBP is critical. (Swisher et al., 2008, p. 54)

As previously discussed due to the influences of the quality of the parent-child attachment, along with a caregiver's capacity to parent, parental histories of trauma, mental illness, and life stress, therapeutic services focused specifically on the caregiver are indispensable for successful treatment for the child. St. Amand and colleagues conducted a meta-analysis of eleven treatment outcome studies and eighteen specific approaches to treatment for child sexual behavior problems and concluded, "it is possible that parental involvement in treatment may be critical" (2008, p. 146). The following excerpts from the data further illustrate this point.

As well, the high percentage of maternal caregivers who experienced multiple forms of childhood maltreatment and who exhibit chronic stress and PTSD symptoms points to the need to provide therapeutic assistance for the caregiver's own issues. (Hall et al., 1998, p. 1059)

Therefore, addressing parental attachment problems remains a vitally important clinical intervention. Treatment for parents also should incorporate parent training, social-relational skills, resolution of trauma remaining from childhood maltreatment, and, where appropriate, an opportunity to mourn the loss of the idealized child and family. (Pithers et al., 1998, p. 139)

With caregivers who have been victimized, resolution of their own trauma may be a prerequisite to their ability to respond effectively to their children's problematic behaviors. To prevent abuse, treatment should foster family health-promoting lifestyles and the development of specific skills in individual family members. (Gray et al., 1997, p. 286)

Given the extensive history of victimization and perpetration in these families, only a balanced approach to treatment is recommended to reconstitute the familial culture essential to the healthy development of children and the prevention of further maltreatment. (Gray et al., 1997, p. 287)

By involving the caregivers in groups, they may develop a social network that allows them to see that they are not alone in their concerns. (Pithers et al., 1998, p. 140).

Outcomes from current research, along with findings from this study, recognize the necessity and benefit for family-based treatment methods for children exhibiting problematic sexual behaviors. Findings suggest that the strongest predictor of positive outcomes for reduction of problematic sexual behaviors was inclusion of parents in treatment.

Coded category: Social Support Systems and Individualized Treatment. The concept labeled Social Support Systems emerged 16 times during coding and Individualized Treatment occurred 14 times. The implication of these conceptual categories reveals ecological aspects of treatment. As previously discussed, child development occurs within varied ecological systems and contextual environments that influence childhood sexual behavior. Additional findings reveal diverse sociocultural factors affect children and sexual development, as well as influence adults who interpret and contextualize child sexuality and sexual behaviors.

There appear to be multiple dynamics that affect parenting adults, within varied ecological environments, that directly and indirectly influence a child's development and functioning (Lovejoy et al., 2000). Therefore, social, familial, and individual factors need consideration when designing interventions for children and families affected by childhood sexual behavior problems. Findings from the data, illustrated in these sample quotes, emphasize the relevant importance for social supports and services for parents and families of children exhibiting sexual behavior problems.

Given the evident psychological distress, familial chaos, impaired parent-child relationships, and disappointment with their child's functioning, one may question whether these parents might need greater than average levels of social support in order to function effectively. (Pithers et al., 1998, p. 139)

To foster the creation of healthy families within which children may grow to become contributing adults, these families need to have access to health services, child care, and linkages with community sources of assistance. Adults who have practical and social support are in a better position to become effective parents than those who feel stressed and alienated. (Zigler, Taussig, & Black, 1992, as cited in Pithers et al, 1998, p. 140)

Because childhood sexual behavior problems occur and reoccur for diverse reasons that reflect dynamics within assorted ecological settings, such as home, school and neighborhood, interventions also need to reflect various ecological supports. These excerpts from the data further highlight the value of ecological support services as reflected in the concept Social Support Systems associated with Effective Treatment.

All children involved, however, do require assistance and guidance from health care professionals as well as parents and schools. (Kellogg, 2009, p. 993)

Thus, in addition to involving caregivers, an adequate response needs to involve partnerships with schools. If treatment providers work cooperatively with special education and school guidance professionals, children can be given more opportunities to enhance their skills. (Gray et al., 1997, p. 287)

Involvement of other adults in the child's social ecology (e.g., teachers) and perhaps peers in treatment may enhance the outcome on SBP of services for older children. (St. Amand et al., 2008, p. 163)

The plan would include providing support and education to caregivers, so that they can make the necessary changes to the child's environment to provide supervision and parenting to prevent further SBP. (Swisher et al., 2008, p. 56)

The larger communities in which children and their families live also constitute important factors; communities may provide support to parents in being effective caregivers to their children. (Bronfenbrenner, 1979, as cited in Elkovitch et al., 2009, p. 595)

In conjunction with the notion of support services and interventions specific for the ecology of the family and child is the concept of designing treatment that reflects the unique needs of each child and family. Although there were various therapeutic components found effective in treatment for child sexual behavior problems, the multiplicity of unique factors related to child sexual behavior problems necessitates an individualized approach for interventions with children and parents.

Treatment for children exhibiting sexual behavior concerns necessitates tailored interventions to meet the developmental stage of the child, and a wide variety of clinical needs of the child and family to ensure the best outcomes (Chaffin, 2008). This concept emerged from the coding and analysis process 14 times labeled as Individualized Treatment.

Though the behavior of children who have sexual behavior problems may look outwardly similar, this does not mean that the children will respond to treatment in the same way. They differ not only in the type and level of sexual behavior they exhibit, but in most other areas as well. These findings suggest a need for differential assessment and individualized treatment approaches. (Hall et al., 1998, p. 1058)

Some children exhibiting sexual behaviors have also experienced child maltreatment or may evidence symptoms of other co-occurring disorders or psychological distress. These unique needs necessitate intervention that further supports the concept of Individualized Treatment as noted in this sample from the data.

By better understanding and conceptualizing the maltreatment-related predictors of sexualized behavior beyond a sexual abuse history, and by taking into account how affective dysregulation may present differently in boys and girls, interventions can be specifically tailored for maltreated children. (Merrick et al., 2008, p. 131)

However, treatment should be individualized and address the child's co-occurring conditions when present, in addition to the SBP. (Swisher et al., 2008, p. 60)

Findings from this study support the current trend in research suggesting that structured CBT interventions, with parent and family involvement, offers an effective approach to treatment for children exhibiting sexual behavior problems (Silovsky & Niec, 2002; Silovsky et al., 2007; Swisher et al., 2008). Completion of CBT, caregiver-involved treatment was associated with accelerated improvements in reduction of sexual behaviors and long-term sustainability (Carpentier et al., 2006; Swisher et al., 2008).

Various evidence-based treatment interventions were recommended and utilized to address non-sexual, externalized, and internalized child behavior problems (Chaffin, 2008; St. Amand et al., 2008). Data indicated that effective treatments are not adaptations of adult or juvenile treatments; rather their explicit design was for children and caregivers (Carpentier et al., 2006; Swisher et al., 2008). There is even some evidence to suggest that, "wait-list studies of preteen children have shown that childhood sexual behavior problems improve naturally with no treatment" (Chaffin, 2008, p. 119).

Ample evidence suggests outpatient treatment related to problematic child sexual behavior yields successful and positive outcomes for children. Even the passage of time may result in reduced or extinguished concerning child sexual behavior. Treatment ideally must be family-based, establish sexual rules, improve safety, increase behavior monitoring, and improve the caregiver-child relationship (Carpentier et al., 2006; Gray et al., 1997; Silovsky et al., 2007). Involvement of the parental caregiver in treatment was essential to successful treatment outcomes. Additionally, support and assistance from diverse ecological systems, within the community, benefits the overall functioning of the child, parent, and family system.

Results from this theoretical analysis propose that problematic childhood sexual behavior is not simply an individual problem rather it is a familial problem, requiring involvement of various ecological systems to support the well-being and positive outcomes for the child, parent and family system. Still, before effective treatment can begin, assessment is necessary to determine the nature of the presenting concerns along with identification of existing risk and protective factors influencing the child and family system.

Sub-theme: Clinical Assessment and related concepts. Effective treatment begins with a comprehensive assessment of the presenting problems. Assessment is a critical component of intervention, yet clinical guidelines for assessment of childhood sexual behavior were difficult to find and vague. In this study, the sub-theme Clinical Assessment includes the following related concepts derived from the coding and analysis process, a) Developmental Ecological Context, b) Differential Assessment, and c) Guides and Tools. The majority of the data related to the sub-theme, Clinical Assessment,

emerged primarily from three source articles with data tagged 32 times during the coding process. Data occurred 14 times under the category Developmental Ecological Context, 12 times coded as Differential Assessment, and eight times data was labeled Guides and Tools.

Information from peer-reviewed literature on assessment of childhood sexual behavior was limited and often reported in the context of screening participants for inclusion or exclusion in a particular study. Assessment procedures applied for empirical purposes were not reported as clinically valid or applicable for utilization in outpatient clinical settings. Yet, as illustrated in the following quote from the data analysis, clinical assessment for childhood sexual behavior concerns is viewed essential for identifying risk and protective factors, and designation of appropriate interventions and supports for the child, family and community.

Clinical assessment can be useful to determine whether the sexual behaviors are typical or problematic and to facilitate decision making about treatment, reunification, and placement. Clinical assessments are recommended after the completion of any necessary investigation. (Swisher et al., 2008, p.53)

Coded category: Developmental Ecological Context. Outcomes from the coding and analysis of literature propose the importance of a comprehensive, individualized approach to assessment within an ecological and developmental context. Ultimately, although it is unclear what constitutes normal childhood sexual behavior; sociocultural influences, developmental and ecological context have much to do with the determination of what defines a child's sexual behavior as problematic. The ecological context considers the diverse influences affecting the child, parent, and family system, while the developmental context is specific to a child's stage of development. The ecological and developmental context of the child has significance for interpretation of the level of

concern associated with a child's behavior and functioning. The category labeled Developmental Ecological Context, as illustrated in the following examples from the data, emerged 14 times during analysis.

The results speak to the importance of context in assessing the nature of sexual behavior in children. We know from studies on human development that children acquire social and cultural roles very early in life. (Friedrich & Trane, 2002, p. 245).

It is not sexual behavior in isolation that is diagnostic but the child's affect, history, and all the contextual variables that provide the basis for an informed opinion." (Johnson, 1993, p. 438, as cited in Heiman et al., 1998)

One of the key issues in evaluating whether a child has exhibited a sexual behavior problem is the consideration of the appropriateness of the behavior relative to the child's developmental level. (Gray et al., 1997, p. 285)

The assessment should also include information identifying the situations or circumstances under which SBP occur, the social environment of the child, the exposure of a child to sexualized materials, and the success, if any, of previous interventions by caregivers or others. (Swisher et al., 2008, p. 53)

Concerns related to child sexual behavior problems can be daunting and emotionally distressing for children, parents, families, and others involved. Although resources exist for professionals to educate themselves on this topic, as evidenced from the results of this study, there is a wide continuum of beliefs influencing conceptualization of what constitutes problematic child sexual behavior. Access to current and relevant information can be overwhelming. Clearly, there is still much to learn and understand. In the absence of current knowledge on childhood sexuality and sexual development, caution is vital for adults and professionals intervening with children identified with concerning and problematic sexual behaviors. Adults may likely rely upon historical beliefs and sociocultural values rather than accurate evidence when

making determinations related to child sexual behavior problems. This was evident from the literature as noted in this example.

Building a body of knowledge in this area is extremely important because some state child welfare systems have enacted procedures that register, segregate, and monitor children identified as having SBP to include placing these children on lifetime public sex offender registries and Internet sites (Carpentier et al., 2006; Thigpen et al., 2003). In the absence of empirically derived knowledge that establishes typical childhood sexual behavior, it is likely that practitioners working within formal helping systems such as child welfare, health and mental health, and juvenile justice will continue to rely on anecdotal information to inform their assessments and impressions. (Thigpen, 2009, p. 77)

Due to limited research, clinicians are encouraged to use careful judgment and make modifications as needed that reflect the unique needs of children and families. Ideally, assessment of childhood sexual behavior necessitates consideration of diverse, developmental, and ecological factors affecting the child and family system.

Coded category: Differential Assessment. Challenges related to differentiating normal versus maladaptive childhood sexual behavior emerged 12 times during the coding process, labeled Differential Assessment. Discerning whether a child's behavior is normal or problematic is a key component of assessment for children exhibiting sexual behavior, as noted from the data by the following example.

Clinicians must first distinguish age-appropriate and normal sexual behaviors from behaviors that are developmentally inappropriate and/or abusive (sexual behavior problems)... and may at times, require more decisive therapeutic evaluation and intervention by a mental health professional. (Kellogg, 2009, p. 992)

Although there are no definitive guidelines on normal childhood sexuality and sexual development applicable to all children within the contemporary United States, there have been attempts made to define parameters of normal versus problematic sexual behaviors exhibited by a child. These early-defined parameters continue to appear in the

literature and often applied in assessment, despite the absence of empirical evidence on child sexual development and sexuality relevant to the modern child.

Gil (1993) discussed criteria to be used to assess if sexual behavior between children is normal sex play or problematic in nature: age difference between the children, size difference between the children, difference in status, type of sexual activity, and the dynamics of the play. The dynamics include the affective quality attached to the sexual act; the frequency, intensity, and impulsivity of the act; and the degree of coercion, threat, or dominance accompanying the sexual activity. (Hornor, 2004, p. 60)

As previously mentioned a child's sexual behavior occurs across stages of development, within ecological systems affected by various sociocultural influences. Sociocultural beliefs, fears, ecological systems and historical information, that may no longer be accurate, also influence adult views and opinions. Thus, clinicians must not underestimate the magnitude of influence of such beliefs, and must recognize the importance of assessment and interventions for children exhibiting sexual behavior concerns, as noted in this quote from the data.

Professionals working with children with SBP need to avoid labeling children due to the far-reaching and long-term impact that certain labels (e.g., sexual offender, sexual perpetrator, child molester, etc.) can have. When children with SBP come to the attention of the courts, judges must make important decisions regarding the care, placement, assessment, and treatment of these children. Due to the diversity of the children and their social supports and needs, individualized responses (rather than broadly applied policies) are recommended. (Swisher et al., 2008, p. 61)

Coded category: Tools and Guides. The related concept coded eight times in the data as Tools and Guides represents suggestions and assessment tools recommended in relation to assessment for children exhibiting problematic sexual behavior.

Early literature reported clinical suggestions that child sexual behavior assessment include a range of information from diverse sources that might aid in determination of

whether a particular behavior was problematic (Gill & Johnson, 1993; Johnson, 1993).

The following examples, coded as Tools and Guides, highlight considerations for assessment.

They recommend assessing: the history of current and past sexual behavior, including past problems; underlying motivation guiding the sexual behavior; the child's affect, response, and feelings regarding the sexual behavior; the use of bribery, trickery, or coercion; the presence of others when the sexual behavior occurs; the description and feelings of the child or other children involved in the sexual activity, and the child's relationship to that child or children; the developmental history of the child, along with the school history, peer relations, in and out of home behaviors, and any history of physical, sexual, or emotional abuse and out-of-home placements; family history with attention to a history of any kind of abuse or neglect, alcohol or substance abuse, psychiatric disorders, divorces, incarcerations, and spousal battering; and the emotional and sexual climate in the home. (Gil & Johnson, 1993, as cited in Heiman et al., 1998, p. 301)

The data collection process from an empirical study inspired this example.

The data collection tool was developed so that it could serve as a structured clinical assessment summary for children's mental health services. (Hall et al., 1998, p. 1049)

- social and physical environment quality and stability
- child welfare history (including stability of contact with primary caregivers)
- child developmental and health histories
- child characteristics, behavior, and relationships
- child maltreatment history
- sexual abuse experience (e.g., characteristics of the sexual acts, perpetrator information, perpetrator/child relationship, response of others to the abuse, etc.)
- child sexual behavior and familial response
- caregiver histories (e.g., childhood maltreatment, substance abuse, participation in antisocial activities, etc.) and current functioning
- parent-child relationship characteristics and parenting practices
- family history, characteristics, and functioning
- family "sexual environment" (e.g., sexual attitudes and beliefs, social interaction style, privacy and boundaries, etc.)
- treatment compliance and outcome (Hall et al., 1998, p. 1049)

Examples such as these provide potential suggestions for assessment of child sexual behavior concerns, however, there was no reported empirical support or demonstrated utility for application of such suggestions in an outpatient clinical setting.

Other data coded Tools and Guide, illustrated other assessment considerations, as noted in these examples from the data of more recent literature.

Obtain a detailed behavioral history of the child and a psychosocial history of the family, looking for any potential sources of stress for the child. (Hornor, 2004, p. 63)

Assessments of children with SBP should be conducted by licensed mental health professionals who have expertise in the following: (a) child development (including sexual development); (b) differential diagnosis of childhood mental health disorders; (c) co-morbid problems frequently seen among children with SBP (including Attention Deficit/Hyperactivity Disorder (ADHD), child maltreatment, child trauma, and conditions that may affect self control); (d) the connection between the social environment and other factors that contribute to the development and maintenance of child behavior, including sexual behavior; (e) current literature on empirically supported treatment for childhood mental health disorders and SBP; and (f) cultural variations in parenting and childhood sexual behavior. (Chaffin et al., 2008, as cited in Swisher et al., 2008, p. 53)

Thorough assessment report should include recommendations for supervision, treatment, the nature of participation of the caregiver(s) in treatment, and how co-occurring issues (i.e., ADHD, posttraumatic stress disorder) will be addressed. (Swisher et al., 2008, p. 53)

There was one tool identified in the data designated as the only standardized instrument designed and empirically studied to assess child sexual behavior, known as the Child Sexual Behavior Inventory (CSBI) (Friedrich, 1997). This tool is a 38-item standardized instrument that relies on maternal, parental report to assess a broad range of childhood sexual behavior among children ages 2-to-12 years old. This innovative assessment tool, frequently utilized in many empirical and clinical settings, was intended to assist in determining whether a child's sexual behavior was normal or atypical as compared to same-aged peers.

The use of the CSBI was evident in many of the selected articles for this study and throughout the extant literature reviewed dating back to 1991. Early literature indicated child sexual behavior was frequently associated as a diagnostic indicator of

child sexual abuse. The CSBI was an inventory tool that screened child sexual behavior along a continuum of normal or maladaptive. Thus, a child screened with the CSBI was inadvertently at risk for consideration as a victim of sexual abuse due to their parent-reported sexual behaviors. However, the CSBI was not intended to be used as a diagnostic tool for sexual abuse, as noted in this quote.

These results clearly indicate that the CSBI, despite its reliability and validity as a screening measure to rate observed sexual behavior, is never to be used by itself to determine if the child has or has not been abused. (Friedrich et al., 2001, p. 46)

Time revealed the limitations of this inventory. As mentioned earlier in the results section, related to the concept Race and Ethnicity, the non-abused sample on which the CSBI was standardized and normed included a small sample characterized as non-White, low-income, male and female children (Friedrich, 1997). Currently, the original sample population does not adequately embody the diverse ethnic and racial cultures, or gender diversity, represented in the United States. Consequently, it appears utilization of the CSBI as an assessment tool, is not generalizable to the children in modern America.

In addition, the parent-rated inventory was standardized on maternal caregivers only; the manual explicitly states the limitations of interpreting results from father's or other caregivers who may be temporary such as foster parents or other caregivers (Friedrich, 1997). Another challenge is reliance on a maternal caregiver's report of a child's behavior that can be easily over or under reported depending on the adult's perspectives and beliefs.

Despite the current limitations of the CSBI, this innovative and valuable instrument has potential for revision and expansion. Unfortunately, according to a

personal correspondence with the publisher PAR Inc. (February 4, 2014), there are currently no efforts reported to revise this product. At the time of this study, there were no other published standardized assessment tools or screening measures, specific to childhood sexual behavior, known to this researcher.

The implication of results, related to the sub-theme Clinical Assessment, reflect the need for greater attention to the topic of assessment for childhood sexual behavior concerns. The following summary reflects the implications of the findings within the major theme, Ecological Interventions, in relation to Clinical Assessment.

Clinical assessment involves determining if the presenting behaviors of concern interfere with a child's typical activities and functioning, and to what degree. Clinicians need also to be aware that childhood sexual behavior typically invites hysterical reactions by caregivers and adults. Often the initial priority for a child presenting under such concerns is safety. Clinicians benefit from awareness that sexual behaviors only variably relate to sexual abuse and are not diagnostic of sexual victimization; meaning that a client presenting with reported sexual behavior concerns may not be a victim of sexual abuse.

Additional findings indicate there are various complex factors that contribute to childhood sexual behavior. The clinician must consider the context of the behavior as it occurred, the developmental age and stage of the child exhibiting the behaviors, as well as the reliability of the observer or reporter of the behavior. The effective clinician must develop a case conceptualization that indicates possibilities of various forms of complex trauma and maltreatment affecting the child, not only sexual abuse, which may include physical abuse, witnessing domestic violence, emotional abuse, and/or neglect.

Case conceptualization necessitates a thorough family history with an assessment of the family system to determine if violence, abuse, or dysfunction occurs in the child's home. Assessing the safety of all children in the home is critical, and determining whether a parenting caregiver is capable of protecting the children is necessary. Risk and protective factors within the family occur as one of three options in risk assessment: Low Risks/High Protective Factors, High Risks/High Protective Factors, or High Risks/Low Protective Factors (Gilgun, 2003). Identification of family functioning in relation to the presenting child assists with risk assessment and future treatment and intervention planning.

Discernment of whether to involve local CPS or law enforcement for investigation and/or family assistance may be necessary. At times, establishing safety is all that a compromised family can do. Safety and supervision are priorities that may involve significant modifications within the family system, such as changes in arrangements of co-sleeping, co-bathing, personal boundaries, and supervision. If the child's concerning sexual behavior was occurring at home between siblings and safety cannot occur, and/or the parent lacks the capacity to provide supervision and support for the children, then a child may need to be temporarily separated from the home.

Ultimately, clinical assessment of the child, family, and other social ecologies are important for identifying risks, competencies, and resources in order to guide intervention and treatment interventions for the well-being of the child and family. The following chapter provides summarized findings from this study, specifically in relation to the points of inquiry and association with the development and design of a conceptual model for assessing childhood sexual behavior concerns.

Discussion: An Ecological Developmental View

This chapter summarizes the findings of my in-depth qualitative thematic analysis of extant literature. Findings culminate in a theoretical conceptualization of childhood sexual development and sexual behavior problems labeled *Ecological Developmental View*. This theoretical model emerged from synthesis of this study's qualitative analysis and findings integrated within a framework of ecological development and ecological systems theory. The following sections recap results of the qualitative analysis organized by each research question of inquiry. Outcomes from this systematic review and analysis of literature revealed the predominant historical conceptualization of child sexual behavior problems was narrow, with a primary focus on the sexual nature of the behaviors viewed as predatory and/or diagnostic of child sexual abuse. The significance of sociocultural beliefs and the influence of diverse ecological dynamics on child sexual development and sexual behavior problems necessitates attention; signifying clear evidence for a necessary paradigm shift related to childhood sexual behavior problems.

A brief overview of ecological systems theory provides background for comprehension of the subsequent theoretical model, Ecological Developmental View. These outcomes culminate in the design of the proposed conceptual model of assessment for childhood sexual behavior concerns and problems elaborated upon in Chapter VIII.

Ecological Systems Theory: Brief Overview

Bronfenbrenner's (1977, 1979, 1989, 1994, 2005) ecological systems theory, also known as the ecology of human development, suggested that human development occurs within various systemic layers, or contextual environments and does not occur in isolation. Presumably, there are distinct variations among assorted derived theories of

human development (Heft, 2001); in this study, any references of human development specifically signify as child development. Ecological environments or systems influence child development from within and between other environments. Individuals within each system influence each other through various transactions that occur between them (Bronfenbrenner, 1979, 1989; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Evans, 2000). Bronfenbrenner proposed that child development occurred within distinct ecological systems, or nested structures; a concept associated with a set of Russian dolls that when opened revealed smaller dolls embedded, or nested within, that collectively comprise one whole unit (Bronfenbrenner, 1977, 1979, 1994). Movement from the innermost level to the outer levels replicates ecological environments associated with child development. Child development viewed through the lens of ecological systems, visually represented in Figure 9, represents nested systems of interactions labeled as the microsystem, mesosystem, ecosystem, macrosystem, and chronosystem.

Bronfenbrenner proposed that the system with the closest proximity to the child is the microsystem where a child interacts, spends a significant amount of time, and includes the child, family, peers, neighborhood, and school (Bronfenbrenner, 1977, 1979, 1986, 1989, 1994, 2005). The child embeds within their immediate familial environment while most direct interactions occur within the microsystem with social agents such as parents, peers, and teachers (Bronfenbrenner, 1986, 1989). The child is not a passive recipient of experiences in these settings, but rather someone who participates in the construct of the settings (Bronfenbrenner, 1986, 1989; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Evans, 2000). A child's biological factors are also part of the microsystem (Bronfenbrenner, 2005; Bronfenbrenner & Ceci, 1994). A critical impact

on development occurs within the immediate environment of the child due to proximal processes, transactions and interactions, which operate to produce and sustain development (Bronfenbrenner, 1989, 1994; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Evans, 2000). This is particularly relevant when considering maladaptive development and disorders occurring in children. This theory suggests that dysfunction in children occurs as a byproduct of influences within the microsystem (Bronfenbrenner, 1977, 1979, 1986, 1989, 1994).

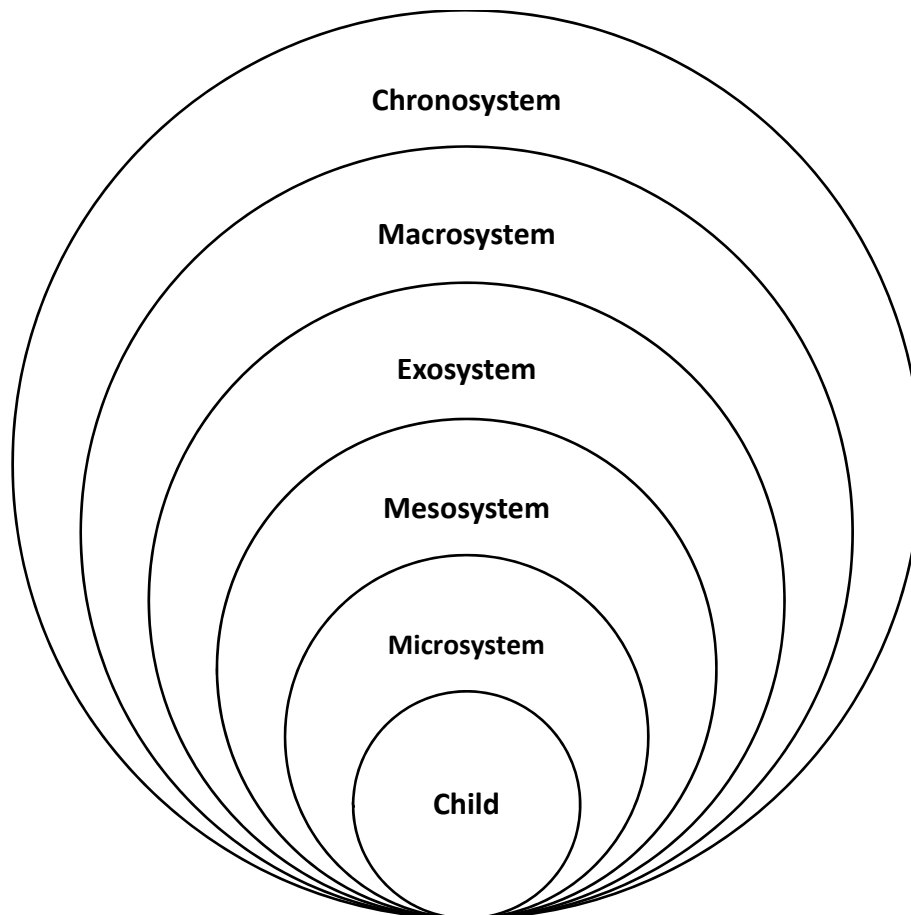


Figure 9. Ecological systems of child development.

The *mesosystem* surrounding the microsystem represents the relationships among the social agents involved in the child's microsystem, and or connections between

contexts that occur among two or more settings containing the developing child (Bronfenbrenner, 1979, 1986, 1994). An example is the relational interactions between parent and school, or school and day care. Children who have experienced rejection from their parents or families may have difficulty developing positive relationships with teachers, friend's parents, or peers for example (Bronfenbrenner, 1979, 1994). The mesosystem is an environment of microsystems (Bronfenbrenner, 1994).

The *exosystem* involves interrelatedness between the context of a social setting, or sociopolitical system that affects the child indirectly (Bronfenbrenner, 1977, 1979, 1986, 1989). These processes occur between two or more settings, at least one of which does not include the child, thereby indirectly influencing the child due to the affect upon the parent. These systems include the parent's work setting, community agencies, religious communities, and sociopolitical systems such as social welfare services or law enforcement. For example, a parent's experience with law enforcement or an employer may influence a child's experience at home.

The *macrosystem* is an overarching system of broad sociocultural values, beliefs, customs, prejudices, laws, and governmental resources, including socioeconomic status, poverty, and ethnicity (Bronfenbrenner, 1977, 1979, 1994). These direct and indirect influences across various ecological systems affect the developmental experience (Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Evans, 2000). Sociocultural, psychological, and political aspects of the macrosystem influence the processes and conditions occurring within the microsystem that affect the child (Bronfenbrenner, 1979, 1986, 1994, 2005).

The nested construct of development concludes with one prominent system of influence that occurs in the outermost layer of the ecological system named the *chronosystem*. The chronosystem represents change or consistency over time, environmental events, and transitions over the life course of an individual, which may be personal, like the death of a parent, or a cultural event such as war, or a global economic recession (Bronfenbrenner, 1979, 1994).

Thematic results from this study suggest clear associations between child sexual development and ecological systems of influence, which primarily include the microsystem and macrosystem, with some influence from the exosystem depending upon the level of community involvement and interactions with sociopolitical agencies. Ultimately, all ecological systems simultaneously influence the family and child's development. Resulting themes, sub-themes, and related coded concepts denote the relevance of ecological, developmental, and familial contextual experiences that affect child development and functioning. The relationship between themes, noted in Table 4, describe the association of themes within ecological systems.

The published work of Belsky offered an important and relevant model for an ecological developmental conceptualization of childhood sexual behavior problems specifically associated with child maltreatment, complex trauma, psychosocial and emotional distress (1993). Belsky (1980, 1993) shared Bronfenbrenner's belief that development occurs within various environmental contexts, or systems. Belsky explored specifically the issue of child maltreatment from an ecological systems model and conceptualized the etiology of child maltreatment occurred from four contexts: the individual, the family, the community, and culture with the child positioned at the core of the model (1980).

Table 4

Themes, Sub-Themes, and Coded Concepts in Relation to Ecological Systems

Major Theme Name Sub-Theme Name	Ecological System	Coded Concepts
Child Sexuality: Ecological Context		
Child Sexual Development	Microsystem and Macrosystem	<ul style="list-style-type: none"> • Normal or Not • Conceptualize CSBP • Socialization • Exposure to Sexual Content • Family Sexuality
Sociocultural Influence	Macrosystem and Exosystem	<ul style="list-style-type: none"> • Reactions and Stereotypes • Ecological Context • Labels and Stigma • Sociopolitical Systems
Developmental Context		
Child: Biological Factors	Microsystem	<ul style="list-style-type: none"> • Age/Stage • Gender • Race/Ethnicity • Cognition
Complex Family Dynamics	Microsystem and Exosystem	<ul style="list-style-type: none"> • Placement Disruption • Life Stress • Economics and Education • Family Perpetrators
Parenting Capacity	Microsystem and Macrosystem	<ul style="list-style-type: none"> • Impaired Attachment • Caregiver Stress • Trauma History • Mental Illness • Adverse Parenting
Complex Trauma		
Child Maltreatment and Trauma	Microsystem and Macrosystem	<ul style="list-style-type: none"> • Sexual Abuse • Physical Abuse • Domestic Violence Exposure • Beyond Sexual Abuse • Emotional Abuse • Neglect
Psychosocial & Emotional Distress	Microsystem and Macrosystem	<ul style="list-style-type: none"> • Behavioral Problems • Psychological Distress • Post-Traumatic Stress • Affect Regulation
Ecological Interventions		
Clinical Assessment	Microsystem and Macrosystem	<ul style="list-style-type: none"> • Developmental Ecological Context • Differential Assessment • Guides and Tools
Effective Treatment	Microsystem, Macrosystem, and Exosystem	<ul style="list-style-type: none"> • Parent Training and Education • Supervision and Safety • Cognitive Behavior Therapy • Family Services • Social Support Systems • Individualized Treatment

In keeping with evolving understanding of child maltreatment from research and clinical experience, Belsky (1993) expanded ecological systems theory and introduced a developmental-ecological analysis of child maltreatment. This approach included the developmental context, the “immediate interactional context,” and “the broader context.” Noted distinctions were aspects *within* the child, innate and or biological such as age, health, and temperament, that play a role in the child’s experience of maltreatment and developmental dysfunction (Belsky, 1993).

Belsky further identified that the parent-child interaction was a key factor related to child maltreatment that occurred within the immediate interactional context within the ecology of the family (1980, 1993). Concurrently, the community, culture, historical values and beliefs, occurred within a broader context that directly and indirectly produced and sustained child maltreatment (Belsky, 1993).

Ecological theory provided the framework for comprehension and synthesis of results from this study in relation to childhood sexual behavior problems. Thematic results of the analysis yielded the major themes of Child Sexuality: Ecological Context, Developmental Context, and Complex Trauma that informed a comprehensive view of childhood sexual behavior based upon the extensive review and analysis of almost thirty years of extant literature. The following section of this chapter provides discussion of the prevailing thematic results related to the points of inquiry in this study.

The chapter concludes with the synthesis of results that culminated in the design of a comprehensive and expanded conceptualization of childhood sexual behavior problems labeled, Ecological Developmental View.

Discussion: Related to Points of Inquiry

How has clinical research and literature contributed to conceptualization of child sexual behavior problems in the United States of America? Results of this qualitative analysis of relevant research found an array of correlating factors and consistent components that contribute to the development of childhood sexuality and problematic sexual behavior. Findings revealed a multiplicity of influences relate to the development and maintenance of child sexual behavior problems. Aspects of all themes and related concepts in this analysis reviewed and distilled were relevant to childhood sexual behavior problems. Conclusions, broadened understanding of this issue beyond the association of childhood sexual behavior with sexual abuse or sexual offending, and included other behavioral, emotional, and psychological conditions. All of the complicated factors affecting the whole child necessitate consideration due to the interrelationship of the developing child and sociocultural influences within and across numerous ecological environments (e.g. home, school, community).

This study found treatment addressing childhood sexual behavior concerns and problems can be highly successful. The analysis suggested strong support for the effective application of cognitive behavioral therapy and family-based treatment programs for children exhibiting problematic sexual behavior. Programs with caregiver involvement and parent behavior training components were found particularly effective. Individualized interventions and treatment attending to the needs of the whole child, including the parent and/or family, not only their sexual behavior, effect change. Children exhibiting sexual behaviors do not necessarily need specialized treatment or

residential programs, nor are children exhibiting problematic sexual behavior destined to mature into juvenile or adult sexual offenders.

How is typical and normal childhood sexual behavior differentiated from maladaptive and problematic sexual behavior among children? Results from this study indicate sexuality is a normal and healthy developmental experience. Findings strongly suggest that sociocultural influences significantly determine what constitutes as normal child sexuality and sexual development. Child sexual behaviors appear to exist on a continuum ranging from typical or expected, to problematic and atypical. According to the analysis, a range of behaviors exists within a variety of problematic sexual behaviors that reflect an array of severity or potential for harm. Behaviors deemed problematic tend to involve other children, include aggression, coercion, threats, and the potential for harm for the child or children involved.

It is important to acknowledge, as with any aggressive or threatening form of behavior, a child involved or targeted by such behavior may incur physical, emotional, or psychological distress. According to extant literature reviewed, children displaying aggressive or harmful behaviors necessitate intervention and treatment that aligns with the level of coercion, threats, and harm involved. Children targeted or involved with problematic sexual behavior may benefit from intervention and treatment relevant to their distress. Findings consistently support the necessity for a thorough, contextual, and comprehensive understanding of the child and sexual behaviors of concern. An assessment that helps discern and differentiate the behaviors and function of the behaviors involved is necessary to ensure appropriate support and intervention for all children and families affected.

Findings from this study suggest research on child sexuality and sexual behavior reflective of 21st century cultural influences in the United States is insufficient. In particular, there was a lack of empirical evidence on childhood sexual behavior and sexual behavior problems that did not rely on parental reports or interpretations of behavior. As well as the absence of research on biological factors such as age, gender, race/ethnicity and cognition, and specifically studies on non-White and non-binary gendered children were insufficient. Minus adequate contemporary knowledge on this topic the objective discernment of whether sexual behavior is normal or not, remains challenging and complex.

How have sociocultural beliefs influenced comprehension and reactions related to childhood sexuality and sexual behavior problems? This study revealed that despite recent research and expanded understanding on the etiology and treatment for children exhibiting sexual behaviors, it appears policy makers, social service agencies, legal systems, communities, and professionals continue to conceptualize problematic sexual behaviors from a limited paradigm. This generates significant fear and reaction, labels and stigma, for families and children identified with sexual behavior problems.

Findings from this study suggest that adult life experiences, mental illness, childhood trauma, parenting capacity, parent-child attachment and sociocultural values and standards, substantially influence adult interpretations, responses and reactions to, and reports of childhood sexual behavior. One conclusion from this study is that childhood sexual behavior can best be understood by the ecological and social context (i.e. developmental, familial, environmental, community) of the child and their behaviors.

Results indicate that not all childhood sexual behavior observed or reported is in fact problematic, pathological, predatory, or evidence of sexual victimization.

What are the related factors contributing to etiology and recurrence of child sexual behavior problems understood within the contemporary United States?

Outcomes from analysis consistently support findings that childhood sexual behavior problems develop and sustain due to a wide variety of social and ecological factors. Diverse biological and developmental variables such as age, stage of development, cognition, and gender affect childhood sexual behavior. Outcomes of analysis indicate that not all children exhibiting problematic sexual behavior have been victims of sexual abuse; nor is childhood sexual behavior diagnostic of sexual abuse. Significant risk factors associated with child sexual behavior problems include exposure to complex trauma and maltreatment, such as domestic or community violence, physical, emotional, and sexual abuse, neglect, psychological distress and disorders, adverse parenting, poor familial and social relationships, and impaired attachment.

This study's results suggest children with no history of concerning sexual behavior might display the onset of such behavior after removal from their home, in response to their traumatic experience. Additionally, removal from the home due to childhood sexual behavior may result in psychological and traumatic distress for the child and family. The etiology and persistence of childhood sexual behavior problems and concerns is complex and multidimensional. Outcomes posit childhood sexual behavior as best understood from a developmental and contextual perspective in relation to risk and protective factors involving varied ecological systems, family and social agents.

How does an empirical foundation inform the theoretical background for an innovative conceptual clinical assessment model? Multiple influences affect children, sexuality and sexual behavior, including family, peers, and community environments; therefore a comprehensive ecological approach to clinical assessment seemed essential. This comprehensive approach necessitates a contextual and individualized assessment of childhood sexual behaviors. It was apparent from the qualitative analysis that related concepts associated with childhood sexual behavior problems represent diverse experiences within various ecological environments (i.e., child, family, peers, and community). Clinicians need a means to identify related risk and protective factors that serve to guide the design and application of relevant interventions and treatment strategies. Clinical assessment outcomes need to identify necessary modifications within primary environments (e.g., home, school, childcare) to create sustainable change in the child's familial and social systems, thereby reducing the disruptive sexual behavior, and improving the overall functioning of the child and family.

A developmental ecological approach to assessment for the child seemed evident and well supported. Integrating results from this study within the framework of ecological systems theory, specific to child development and child maltreatment, offered an expanded and contemporary view of childhood sexual behavior problems. This new paradigm, Ecological Developmental View, directly influenced the development of a research-informed conceptual model of assessment for childhood sexual behavior concerns and problems later detailed in Chapter IX. Ideally, the outcomes from this study contribute to improved capacity for clinicians to feel competent and reassured when

working with children exhibiting sexual behaviors; thereby improving options, interventions, and outcomes for children, their families, and communities.

New Paradigm: An Ecological Developmental View

The resulting Ecological Developmental View of childhood sexual behavior problems depicted in Figure 10 illustrates the overarching influence of Sociocultural Values and Beliefs, within the macrosystem, which affect child development directly and indirectly across other ecological systems individually and collectively. The macrosystem represents laws and societal standards implemented by sociopolitical systems such as politicians or social service agencies, as well as values and beliefs that influence perspectives that shape individual or collective values and actions. As mentioned in the findings from this study, the sub-theme Sociocultural Influences emerged as strongly associated with a range of reactions from adults in response to childhood sexuality, sexual development, and sexual behavior; including determination of what is normal or not, and how to respond when there were concerning sexual behaviors.

Various biological factors directly affect child development, including influences within the ecological context of the microsystem, where most interactions with social agents, such as parent, family, and peers occur. The circle shapes represent Developmental Factors: Microsystem as illustrated in Figure 10. Child development, including sexual development and child sexuality, derive from co-occurrence of behavioral and social-emotional maturation of the child noted in the figure by the large arrow.

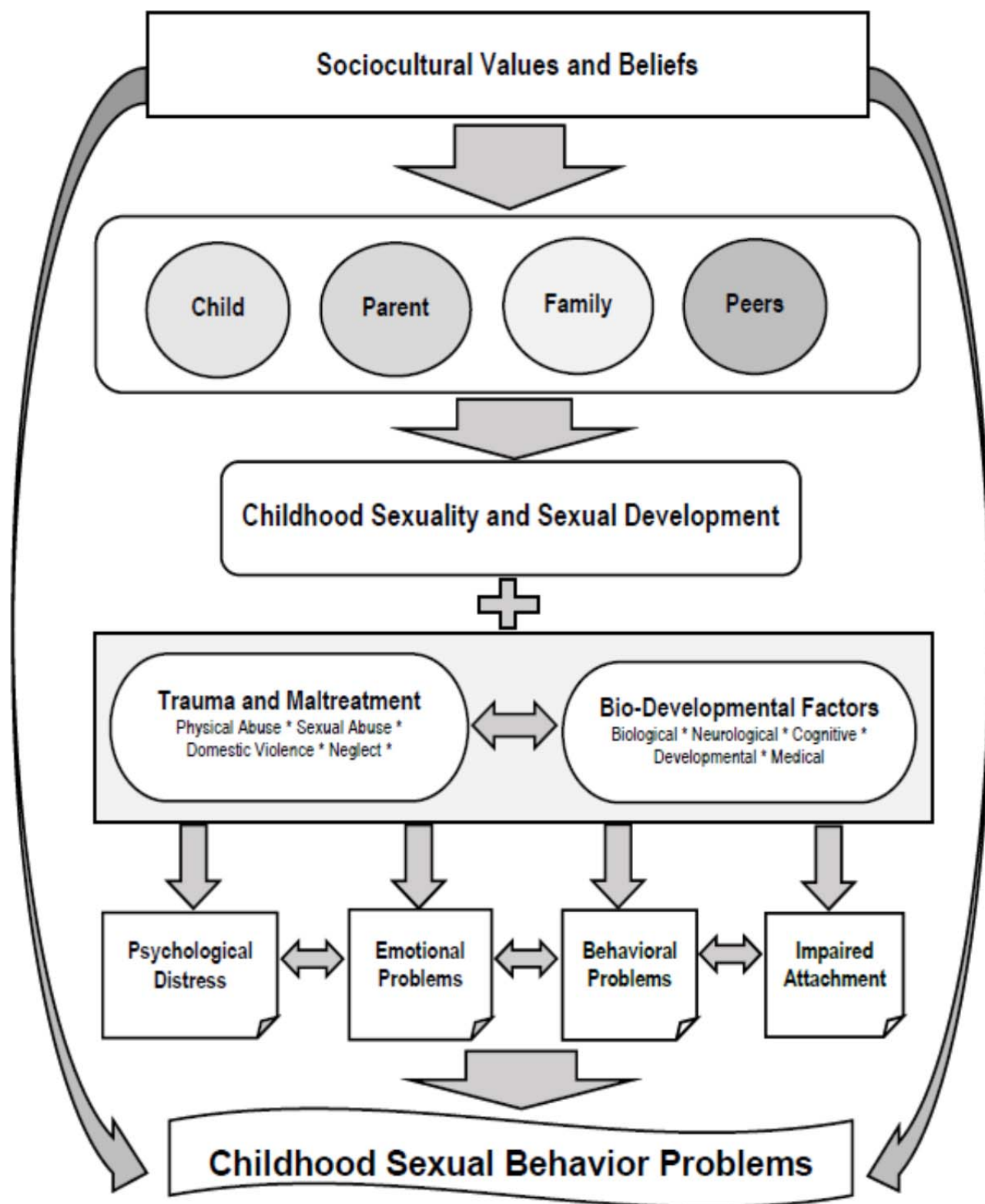


Figure 10. Ecological Developmental View of childhood sexual behavior problems.

Specifically, as reported in the results summary, familial factors, the parent-child relationship and socialization highly affect the interpersonal interactions and emotional development of the child. Distinct influences linked to childhood sexuality and sexual behavior that emerged in this study were biological factors including age, stage of development, cognition, race and ethnicity, family sexuality and exposure to sexual content. All of these occur within the context of the microsystem affected by influences of the macrosystem.

Findings indicate that a multiplicity of factors may effect a child's sexual development and expression of sexual behavior beyond sexual abuse. Various biological - developmental factors affect the developmental process and a child's behaviors. These encompass a range of effects such as organic medical conditions, neuro-biological factors, developmental delays, and cognitive capacities. Additionally, it is evident a clear and strong association exists between childhood sexual behavior and the interjection of physical or sexual abuse, exposure to violence and neglect, and/or other forms of trauma. These diverse influences, exhibited in Figure 10, illustrated by the addition symbol that connects the rectangular shape, Childhood Sexuality and Sexual Development, with two oval shapes, Trauma and Maltreatment and Bio-Developmental Factors, that represent the range of significant factors.

This array of influences appear to shift the developmental trajectory of the child resulting in psychological, social, and emotional distress. Distress and disruption within the microsystem results in the form of arrested development, exhibited through relational problems, emotional and behavior problems, psychological disorders, and impaired attachments. The arrows in Figure represent the ecological transactions that affect the

child as they occur within and between risk and protective factors. Consistently, findings infer that childhood sexual behavior problems result from a multiplicity of complex factors occurring and co-occurring within various dimensions of a child's life inclusive of the family unit.

Therefore, comprehension and assessment related to childhood sexual behavior problems and concerns must encompass the child, parents, and family system from an ecological and developmental framework. The following chapter elaborates upon the integration and association of ecological theory in relation to child development, child maltreatment, and childhood sexual behavior that specifically informed the design of conceptual assessment model introduced in Chapter IX.

Theoretical Framework: Integrated Ecological Assessment

Ultimately, there remains much to discover and understand about child sexuality and childhood sexual behavior problems. This issue presents as difficult and emotionally distressing for many adults, families, and communities. Limited assessment options available to psychologists and clinicians applicable in outpatient clinical settings motivated the development of a conceptual model for assessment. An assessment model that integrates the resulting Ecological Developmental View of childhood sexual behavior broadens knowledge and comprehension of this issue.

Resulting sub-themes and concepts, in conjunction with the Ecological Developmental View, evolved as components for inclusion into an innovative conceptual approach for assessment of childhood sexual behavior concerns and problems. The components embedded within the structure of ecological theories provide a comprehensive, integrated approach to address aspects of childhood sexual behavior from a developmental, contextual, and transactional format. Assessing conditions of the family and social ecology and other environmental influences appeared relevant for the purpose of assessment, to enhance understanding, awareness, and options for key adults in relation to the child's behaviors, safety, and needs.

The next section highlights aspects of clinical assessment applicable to children, followed by a concise review of specific ecological theories that informed the framework for the conceptual assessment model, detailed in the next chapter.

Psychological: Clinical Assessment

Clinical assessment involves a comprehensive method integrating information from multiple sources, such as various informal and formal tests, as well as information from personal and collateral interviews (Groth-Marnat, 2003). A systemic approach to assessment is not concerned with diagnoses, but seeks to understand the problem in terms of relationships, systemic difficulties, patterns triggering or perpetuating problems, and communication patterns (Groth-Marnat, 2003). Assessment from a solution-focused perspective seeks to recognize strengths and solutions while deliberately avoiding identification of problems (Framingham, 2011). Methods of assessment vary dependent on the individual, the presenting concern, and the referring question or purpose for the assessment. Standards established for clinical and psychological assessment offer guidance for best practices within the varied professional licenses. Regardless of the assessment approach, clinicians benefit from adherence to a professional code of ethics and standards of practice relevant to their professional training and license.

Parents and caregivers are integral to the child assessment process (Groth-Marnat, 2003). Often the parent provides the behavior observations and completes parent rated inventories in relation the child. This poses some unique challenges particularly when parents may not be functioning well themselves, if they have limited parenting capacities, or other reasons for defensive or inaccurate reporting. Therefore, collateral information from diverse sources often provides the most accurate view of a child's ability to function. Discrepancies are often best identified through involvement of collateral information that helps inform possible factors contributing to challenges, and/or risk and protective factors for the child.

The conceptual model designed from the results of this study offers a six-component approach to assessment embedded within an ecological framework. The model labeled Integrated Developmental Ecological Assessment Approach (IDEAA) was designed to enhance comprehensive understanding of childhood sexual behavior deemed concerning or problematic. The IDEAA model identifies ecological factors from various systems or environments that influence the development and recurrence of a child's problematic sexual behavior. In doing so, the model helps to discern behavioral etiology and identify associated risks of a child's presenting behaviors, while differentiating healthy, typical childhood sexual development from concerning or maladaptive sexual behaviors. The IDEAA model provides the clinician with an ecological lens to view the presenting sexual behavior while identifying risk and protective factors to assist with planning for treatment, interventions, and safety for the child and family. The following section summarizes relevant aspects of ecological theories specially related to child development, child maltreatment, and child pathology, which were relevant to the model. Readers are encouraged to reference the complete works of the cited authors for a more comprehensive understanding of each of the referenced ecological theories.

Ecological Theory: Child Development and Child Maltreatment

Theoretical concepts synthesized for the IDEAA model derived from Bronfenbrenner's early work on ecological systems theory (1977, 1979, 1986, 1989, 1994), Belsky's (1993) developmental-ecological conceptual model, and the works of Cicchetti and associates (Aber & Cicchetti, 1984; Cicchetti & Aber, 1998; Cicchetti & Lynch, 1993; Cicchetti & Rizley, 1981; Lynch & Cicchetti, 1998) specific to ecological interactions related to child maltreatment and developmental psychopathology.

Collectively these works integrated child maltreatment, child development, and the significance of supports and stressors within the caregiver-child relationship and diverse ecological settings.

Varied theories related to ecology and human beings from a psychological, developmental, and sociological perspective emerged in the 1960s in the United States. Diverse disciplines over the past 50 years adopted the term *ecological psychology*, with each providing their own unique perspective. At differing times, various psychologists have applied aspects of ecological psychology in development of their work. Theorists drew attention to the relevant importance of conceptualizing psychopathology within a continuously unfolding, dynamic, and ever changing context (see for example Belsky, 1993, Cicchetti, 1993, 1996, 2006; Cicchetti & Aber, 1998; Cicchetti & Lynch, 1993; Cicchetti & Rizley, 1981; Lynch & Cicchetti, 1998).

Bronfenbrenner's theoretical model of *ecological systems theory* was initially constructed and published in the 1970s. His work spanned more than 60 years of empirical research and scholarly contributions to the field of human development. Bronfenbrenner's theoretical and empirical studies had a significant and widespread impact on the field of human development and ecological systems. Ecological systems theory acknowledged the ongoing, necessary and intrinsic interactions of each unique individual between others and their environments (Bronfenbrenner, 1994). Over time, Bronfenbrenner expanded his theory later known as *bio-ecological systems theory* (2005). Pertinent to this study, limited aspects of Bronfenbrenner's early versions of ecological systems theory (Bronfenbrenner, 1977, 1979, 1986, 1989, 1994) were applied to the IDEAA model.

Ecological systems theory derived from analysis and integration of results from empirical investigations conducted by various researchers across diverse disciplines. Bronfenbrenner credited his own work with important influences from predecessors and contemporaries such as Leo Vygotsky and Kurt Lewin. In 1979, Bronfenbrenner published *The Ecology of Human Development*, which had broad influence on the way psychologists, and others approached the study of human beings, particularly children, and their environments.

Traditionally, research conducted on child behavior primarily occurred in laboratory settings exploring the internal factors of the developing child. Bronfenbrenner questioned the limitations of studying child behaviors in contrived settings; hence, he began conducting studies using a naturalistic research method that occurred in the *context* of the child's natural environments (1979). The relevant importance of the interaction of human beings, between and within their environments, seemed critical to understanding the breadth of human development (Bronfenbrenner, 1979). The emphasis of naturalistic studies was less on development per se, and more on the contexts in which development occurred. Specifically, interest was in person-context interrelatedness, or transactional processes, which occurred within and between the various environmental systems and the individual (Bronfenbrenner, 1979, 1989; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Evans, 2000).

Bronfenbrenner proposed that the environment affected the child and the child influenced the environment (1986, 1989, 1994). Roles, norms, and rules embedded within the context of each environment, or system, contributed to the development of the child. These nested environmental systems, with bi-directional influences within and

between the systems, shaped a child's adaptive and maladaptive development (Bronfenbrenner, 1989; Bronfenbrenner & Evans, 2000). Within this theory of ecological systems, optimism was associated with the knowledge of the existence of an interrelationship between environments and the child. Therefore, it was conceived that environments, which influence maladaptive child development, might be manipulated to promote positive child development. Bronfenbrenner was a visionary with an overriding hope that the contributions he made to the field of child development would influence practitioners, educators, policy makers and others to consider the potential for each child to develop to their fullest capacity (Bronfenbrenner & Evans, 2000).

Advancements in the concept of the ecology of human development signified changes in conceptualizing the powerful influences of varied environmental impacts, not only upon child development, but also on the developmental aspects of psychopathology (Aber & Cicchetti, 1984; Cicchetti, 1996, 2006; Cicchetti & Aber, 1998). The theory of developmental psychopathology emerged and recognized that child disorders and dysfunction resulted from the dynamic interplay between the individual and various internal and external contexts (Cicchetti, 1996, 2006). The biological, psychological, and social aspects of normal and abnormal development across the life span were considered rather than viewing pathology as inherent in the individual (Cicchetti, 1993, 1996, 2006; Cicchetti & Aber, 1998). This was particularly relevant in shifting blame and sole responsibility for maladaptive behaviors away from the child, out toward other individuals and influences within the various environmental contexts, creating a systemic context for support and intervention (Cicchetti, 2006; Lynch & Cicchetti, 1998).

Concurrent with these theoretical developments, Belsky (1980) proposed an ecological point of view specifically related to child maltreatment that incorporated both psychological and sociological perspectives. Belsky conceptualized a framework of understanding to account for the etiology of child maltreatment with the hope of enhanced efforts to reduce incidences of child maltreatment. Similar to the concept of developmental psychopathology (Cicchetti & Aber, 1998; Cicchetti & Lynch, 1993; Cicchetti & Rizley, 1981), Belsky's multi-dimensional approach expanded developmental theories, creating an integrated model that expressly considered child maltreatment the result of biological, psychological and sociological characteristics (1980, 1993). Belsky noted Bronfenbrenner's influence in his work and reflected the similarities between their ecological structures (Belsky, 1980; Bronfenbrenner, 1979). Belsky's ecological model proposed four contextual systems affecting child development between and within each system. Belsky described (a) the ontogenic developmental system, as the individual; (b) the microsystem, or the family unit that included the child; (c) the exosystem, the elements immediately outside the family systems such as extended family, community, and economic factors; and (d) the macrosystem, or broader culture such as societal attitudes, prejudice, historical and cultural values (Belsky, 1980).

Belsky (1993) later expanded the ecological model as a *developmental-ecological* framework that perceived behavior and social functioning, specifically child maltreatment, from a conceptual and interactional perspective. He incorporated awareness that each individual, caregiver, and child brought differing aspects to their primary microsystem (i.e., family unit). The systematic levels of the developmental-ecological model interacted and transacted with each other over time in

shaping individual development and adaptation (Belsky, 1993). Belsky came to understand, along with his colleagues in the field, (e.g., Cicchetti & Aber, 1998; Cicchetti & Lynch, 1993; Cicchetti & Rizley, 1981), that child maltreatment commonly resulted in child psychopathology and was best understood from a developmental context, an immediate interactional context, and broader sociocultural context (Belsky, 1993).

Cicchetti and Rizley (1981) furthered Belsky's developmental-ecological conceptual explanation of child maltreatment adding a transactional component to the ecological model. This model was known as the *ecological transactional* model of child maltreatment. The ecological transactional model accounted for the biological, psychological, and social composition of contextual environmental structures, adding an interactional dimension that focused on the transactions among and between risk and protective factors as related to child dysfunction and adaptation (Lynch & Cicchetti, 1998). These risk factors were divided into two broad categories: *potentiating factors*, which increased the probability of risk for maltreatment and *compensatory factors*, which decreased the risk for maltreatment (Cicchetti & Lynch, 1993; Cicchetti & Rizley, 1981). Within these two categories, distinctions were made for *transient factors* and *enduring factors*.

According to Lynch and Cicchetti (1998), enduring factors represented more permanent conditions or characteristics. Enduring compensatory factors, considered protective factors, included relatively permanent conditions related to a decrease in stress and risk factors (e.g., a parent's history of positive parenting, and a history of good, solid support sources). Enduring potentiating factors are conditions or attributes considered more permanent that increase risk. These may include child, parental, or environmental

characteristics that may be biological, historical, psychological, or sociological in nature (e.g., a caregiver with a history of childhood abuse). Transient compensatory factors act as buffers and may protect a family from stress; not considered permanent, they are associated with decreased risk (e.g., a caregiver's recent employment or recent sobriety). Transient potentiating factors are factors that increase stress and risk considered short-term in duration (e.g., temporary loss of a job or marital problems) (Lynch & Cicchetti, 1998).

Dysfunction and maladaptation more likely occurred when potentiating risk factors outweighed protective and buffering compensatory influences; whereas adaptive functioning more likely resulted when the opposite was present (Cicchetti, 1996; Lynch & Cicchetti, 1998). It became evident that outcomes relied upon the dynamic interaction of potentiating or compensatory factors rather than simply the absence or the presence of them. Recognition of these risk and protective factors, specifically related to child development, child maltreatment, and psychopathology provided opportunities for interventions and systemic change (Cicchetti & Lynch, 1993; Lynch & Cicchetti, 1998). An ecological transactional perspective provided a method of analysis and intervention for maltreated children by focusing not only on the parent or the child, but also on their interactions with each other, as well as their social environment, culture, and macro influences (Lynch & Cicchetti, 1998).

Aspects of these varied ecological theories related to child development and child maltreatment from an ecological perspective provided a multidimensional framework for comprehension and assessment for childhood sexual behavior concerns and problems. Adequate assessment of childhood sexual behavior necessitates exploration of the child

and their behaviors across various ecological environments, within a developmental context, in order to gain an inclusive understanding of the behaviors and their effect upon the child, family, and community. The focus for an ecological assessment requires consideration and inclusion of the child, family, social environment, and cultural influences rather than isolated attention solely on the child and their behaviors.

Integrated Results: A Developmental Ecological Framework

Ecological systems theory was a logical structure for conceptualization of childhood sexual behavior concerns and problems. The conceptual model, Ecological Developmental View, provides an enhanced theoretical conceptualization of childhood sexual behavior problems that exemplified the robust association between child maltreatment and trauma, and development of childhood sexual behavior problems and dysfunction. Various thematic concepts reflected the sociocultural influences and multidimensional perspectives related to children exhibiting problematic sexual behaviors.

Ecological developmental theories related to child development and maltreatment synthesized well as an integrated approach to comprehension of the multiple dimensions of childhood sexual behavior concerns and problems. Considering the multiplicity of factors associated with child development, the onset and recurrence of childhood sexual behavior problems, the association of maltreatment and trauma with childhood sexual behavior, and the impact of risk and protective factors across various environments, the application of an integrated developmental ecological approach to child assessment of sexual behavior problems seemed logical and practical. Features of referenced ecological theories combined with the qualitative results from this study blended as a conceptual

model for assessment of childhood sexual behavior concerns and problems. Refer to Table 4 for review of details on the themes, sub-themes, and related concepts.

Extant literature from the realm of ecological theory posits that experiences within the immediate environment of the child have significant effect on the production and maintenance of the child's development (Belsky, 1980; Bronfenbrenner, 1979, 1986, 1989, 1994, 2005; Cicchetti & Lynch, 1993; Lynch & Cicchetti, 1998). This is particularly relevant when considering maladaptive development and disorders that erupt in children. Aspects of ecological theory aligned with a major theme from this study, labeled Child Sexuality: Ecological Context that comprised aspects of child sexual development and sociocultural factors of influence that directly and indirectly shape the child's capacity to function in an adaptive or maladaptive manner.

The theoretical premise that dysfunction in children occurs as a byproduct of functions or malfunctions within the microsystem that includes the child, family, peers and school (Belsky, 1980, 1993; Cicchetti & Lynch, 1993; Lynch & Cicchetti, 1998) has a strong association with the resulting core themes, Child Sexuality: Ecological Context and Developmental Context. Both propose that children's sexual development and sexual behaviors reflect various developmental factors of influence within the microsystem such as socialization, family sexuality, exposure to sexual content, as well as adult opinions of what childhood sexual behaviors are conceptualized as normal or not.

The sub-theme Sociocultural Influence comprised diverse concepts found to affect conceptualization of childhood sexual behaviors and problems (e.g., Reactions and Stereotypes, Labels and Stigma, Sociopolitical Systems, and Ecological Context). Findings strongly suggest that sociocultural influences of the macrosystem directly and

indirectly affect individuals within the microsystem that have significant influence on the child, and the determination of how childhood sexual behavior is responded to by adults and communities.

Therefore, it was determined that assessment of child behavior, specifically sexual behavior that may be adaptive or maladaptive, required comprehension within the ecological context and systems affecting the child and their behaviors. Children need understood within their unique environments. Comparing child biological, psychological, social-emotional, and developmental functioning to sociocultural norms and standards can be useful only if the standards and norms applied represent the child completing the assessment. Understanding how a child's functioning compares to other similar peers may provide opportunities to identify strengths and concerns in order to intervene appropriately.

The major theme Developmental Context represents the innate aspects within the child that play a role in the child's experience, specifically related to child maltreatment and developmental dysfunction (Belsky, 1980; Bronfenbrenner, 1986, 1994; Bronfenbrenner & Ceci, 1994). As supported in ecological-developmental theory, examples of these influential factors include the child's age, health and behaviors (Belsky, 1980). The sub-theme Child: Biological Factors reflected the relationship between factors of age, stage of development, cognition, and race and ethnicity, as influencing child sexual behavior in diverse ways. Some biological factors were minimally informed by extant research (i.e., age, stage) while others were inadequately understood (i.e., cognition, race and ethnicity). Despite discrepancies in findings, there

emerged a solid connection between a child's biological factors with sexual development and sexual behavior.

Diverse direct and indirect influences from the outer dimensions of the ecological system, such as the mesosystem, exosystem, or macrosystem for example, also affect the child's functioning and development (Bronfenbrenner, 1986, 1989, 1994; Cicchetti, 1996, 2006; Cicchetti & Aber, 1998; Lynch & Cicchetti, 1998). Specific to childhood sexual behaviors, consideration of whether a child's sexual behaviors are developmentally appropriate necessitates conceptualization from both a developmental and ecological perspective within the socio-cultural (i.e., norms, values, standards) context of the child and family. Developmental Context was another major theme associated with the biological and social-emotional development of the child influenced by interactions within the microsystem such as the parent-child relationship, life stress, and family dynamics. The microsystem does not occur in a vacuum void of influence; it occurs within larger systems that either positively or negatively affect processes occurring within, and between other contexts (Belsky, 1980; Bronfenbrenner, 1986, 1994; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Evans, 2000; Cicchetti & Rizley, 1981; Lynch & Cicchetti, 1998).

These environmental systems are comprised of individuals who interact within and between settings. The interactions and relational transactions, or proximal processes that occur are directly and indirectly responsible for a child's development (Bronfenbrenner, 1986; Bronfenbrenner & Ceci, 1994; Bronfenbrenner & Evans, 2000; Cicchetti & Rizley, 1981; Lynch & Cicchetti, 1998). Thus concluding that child

dysfunction, delays or disorders may evolve and sustain because of proximal processes and conditions of the developing child's microsystem.

From a developmental-ecological perspective, Belsky (1993) determined that the parent-child interaction and immediate interactional context of the microsystem were key factors related to child maltreatment. Studies indicate that disrupted attachment may be a risk factor for sexual behavior problems (Pithers et al., 1998) as well as contributing to other family risk factors (e.g., poor boundaries, sexualized family environment) (L. A. Rasmussen, 1999, 2004). The parent-child relationship and quality of attachment are critical for adaptive development and healthy functioning (Cook et al., 2003, 2007; Erikson, 1994; Pithers et al., 1998). Analysis from this study supported the significance of the parent as related to childhood sexual behavior further suggesting that various relational and transactional processes within the microsystem significantly affect child sexual behavior problems.

In this study, two sub-themes emerged, Complex Family Dynamics and Parenting Capacity, both highly associated with concepts related to child development, childhood sexual behavior and other social-emotional and behavioral issues. The association among these themes suggests the ecology of the family occurs within and between the microsystem, mesosystem, and exosystem. Extant literature identified family adversity, poverty, stressful familial life events, conflicted parent-child relationship, and adverse parenting, were all significant predictors of childhood sexual behavior problems (Bonner et al., 1999; Friedrich et al., 2003; Pithers et al., 1998). Due to the broad range of variables affecting the formative and developmental aspects of a child across varied

environments, there was clear benefit for viewing childhood problematic behavior through an ecological lens.

Additionally, the community, culture, historical values, and beliefs, represented in the broader context of the macrosystem, directly and indirectly influence the production and sustainment of child maltreatment (Belsky, 1980, 1993). The impact of these on the caregiver, collectively affect their capacity and style of parenting as either nurturing, supportive and attentive, or adverse, coercive and neglectful. Because protective factors (e.g., employment, maternal education, nurturing parenting skills, social support system) also influence a child's development, it is essential to identify the ecology of the parent-child relationship and caregiver's capacity to parent when assessing problematic child sexual behavior.

Many identified factors of influence perceived as risk factors affect child development and functioning within the immediate child-family environment, and among the broader community. Resulting concept categories represent the various risk factors related to the parent and family unit linked to childhood sexual behavior problems. The concepts labeled Life Stress, Family Income, Parental Education, Adverse Parenting, Trauma History, Family Perpetrators, Domestic Violence Exposure, Psychological Illness, and Placement Disruption all affect the ecology of the family and the child's developmental experience.

Assumedly, increased protective factors positively affect child development and functioning while increased risk factors positively influence child dysfunction and maladaptive behaviors. These factors could either be enduring and relatively permanent or transient factors that were intermittent or shorter in duration. Risk factors and

protective buffers involve aspects of the child, parental or environmental characteristics, and/or may be biological, historical, psychological, or sociological in nature (Cicchetti, 1996, 2006; Cicchetti & Lynch, 1993). Seemingly, maladaptation more likely occurs when vulnerability and risk factors outweigh protective and buffering influences (Lynch & Cicchetti, 1998). Yet, it was not the absence or the presence of risk or protective factors that provide a specific outcome, but rather their dynamic interactions that were significant (Lynch & Cicchetti, 1998). Cicchetti and colleagues consistently found transactions among risk and protective factors specifically relate to the occurrence of child maltreatment and community violence (Aber & Cicchetti, 1984; Cicchetti, 1996; Cicchetti & Lynch, 1993; Cicchetti & Rizley, 1981; Lynch & Cicchetti, 1998).

The major theme, Complex Trauma associated with child sexual behavior problems, related strongly with the ecological transactional model applied to child maltreatment and violence (Aber & Cicchetti, 1984; Cicchetti & Lynch, 1993; Lynch & Cicchetti, 1998), and developmental psychopathology (Cicchetti, 1993, 1996, 2006; Cicchetti & Aber, 1998; Cicchetti & Rizley, 1981). Complex Trauma includes the sub-themes Child Maltreatment & Trauma and Psychological & Emotional Distress. Child maltreatment was significantly associated with maladaptive childhood sexual behavior.

All aspects of maltreatment were identified as associated with childhood sexual behavior problems; many occurred within the microsystem of the family either directly, between the caregiver and child (i.e., physical abuse, sexual abuse, emotional abuse, and neglect), or indirectly (exposure to domestic violence or other traumatic events). The concept of developmental psychopathology offers another means for conceptualizing childhood sexual behavior problems in relation to child maltreatment. The ecological

concept of developmental psychopathology recognized the effect of multidimensional factors from varied ecological contexts (biological, psychological and social) upon the maltreated child, and the resulting development of pathology and maladaptive behaviors (Aber & Cicchetti, 1984; Cicchetti, 1996; Cicchetti & Aber, 1998). This theory echoes the resulting concept model, Ecological Developmental View, of child sexual behavior problems.

Collectively, these varied ecological theories and concepts provided a framework for comprehending child development within diverse contextual environments, including family and social agents that directly or indirectly, affect a child's adaptive or maladaptive functioning. Resulting themes and concepts, including the Ecological Developmental View, synthesized as the integrated developmental ecological approach to assessment. Details of this six-component assessment model follow.

An Integrated Developmental Ecological Assessment Approach

This qualitative study culminates with an Integrated Developmental Ecological Assessment Approach (IDEAA) for use by psychologists and clinicians in outpatient clinical settings for assessment of childhood sexual behavior concerns and problems. Findings from analysis and this researcher's clinical experience, synthesized with aspects of developmental and ecological theories previously reviewed, provided a framework for comprehension of a child's adaptive and maladaptive development and functioning. This model offers a structure for comprehension of the child and their behavior within the context of their familial and social environments.

A developmental ecological lens offers a useful and beneficial framework for conceptualizing childhood sexual behavior and social functioning from a contextual and interactional perspective. This integrated conceptual framework does not assume the child's sexual behaviors are maladaptive, intrusive, harmful, or predatory, and broadens potential outcomes, options, and interventions for children, families, and communities. Ultimately, a developmental ecological approach for assessment emphasizes the importance of understanding human health and pathology in their fullest contexts and systematically considers biological, psychological, and social factors and their complex interactions.

The conceptual assessment model is comprised of six-component design. A component is one part of something, a part of a whole, or a part of a system (Component, 2014) which is appropriate for an ecological assessment approach that necessitates application of all parts of a child's ecology for effective comprehension of the whole.

The IDEAA model offers a framework that synthesized themes from the analysis in this study integrated into six-components for assessment. An essential task of the assessment is viewing the child's behavior from a developmental ecological lens, exploring various dimensions, risk, and protective factors in a child's life experience and development to determine how they influence each other. Discerning what changes in the ecological environments may lead to desired outcomes for the child and family is another aspect of the assessment.

IDEAA is comprised of the following six-components: a) Bio-Ecological Development, b) Child Sexuality, c) Psychosocial Emotional Development, d) Parent-Child Relationship, e) Family Ecology, and e) Complex Trauma. IDEAA is a conceptual model for assessment of children ages two to 12 years old who exhibit concerning or problematic sexual behaviors. The name associated with this assessment specifically does not include words such as sexual, sexualized, sexually aggressive, or offender. This was intentional to prevent the inadvertent perpetuation of labeling that leads to stigmatization of children who exhibit behaviors considered sexual due to their relationship to mature sexual knowledge, or their contact with genital or private body parts.

The IDEAA model intends to discern the function of the behavior and potential influences contributing to the sexual behavior, and to assess the parent-child relationship, and the caregiver's capacity to parent and cope with their child's behaviors. IDEAA outcomes offer an ecological conceptualization of factors related to etiology and recurrence of the concerning behaviors, developmental and psychosocial emotional functioning, and family dynamics and parenting capacity, as guidance for treatment

interventions and community supports intended to improve the child and family's overall well-being and functioning within their community.

The six-component design, depicted in Figure 11, was determined based on prominence of emerging themes and concepts related to child sexual behavior problems. This model does not begin with the assumption that a child exhibiting sexual behavior was a victim of sexual abuse or is a sexually aggressive predator. Results from review and analysis of extant literature indicate there is no single causative factor for child sexual behavior problems, rather there are interactions of various dimensions, within and between ecological systems, which affect the development, context, and display of child sexual behaviors. A crucial part of the assessment task is determining how various dimensions and factors in a child's life influence each other, interrelate between and within various contextual environments, and decide what changes in the system may lead to desired outcomes and safety for the child and family.

The IDEAA model represented by concentric circles and circular shapes, illustrates the flow of interaction between various elements and influences continuously affecting the development and functioning of the child. Similar to the nesting structure of ecological systems theory, the middle circle labeled "Child" embeds within diverse influential environmental systems and proximal processes. The central circle is comprised of a three-circle Venn diagram showing the overlap and interactions between family, parent, and peers, all influential social agents and environments entrenched within the greater community, represented by the surrounding circle. The components of assessment illustrated on the outer circle of the model, represent six distinct areas for examination and scrutiny specific to childhood sexual behavior.

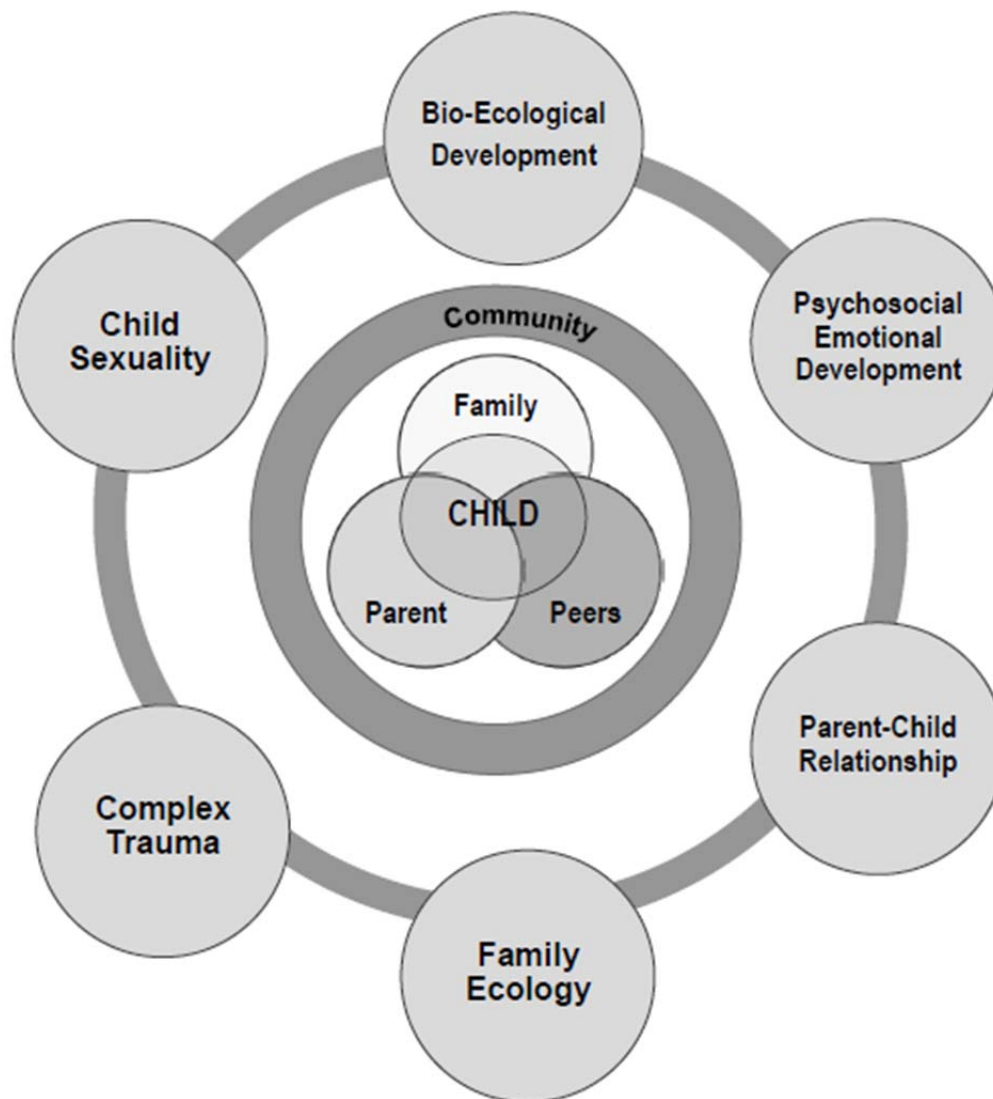


Figure 11. Integrated developmental ecological assessment approach (IDEAA).

Clinical assessment approached from six dimensions within the child's ecological system include the following components as seen in Figure 11.

1. Bio-Ecological Development (e.g., biological and developmental functioning).
2. Child Sexuality (e.g., child sexual development, modeling of sexuality, family sexuality, exposure to sexual influences).

3. Psychosocial Emotional Development (e.g., socialization skills, externalized and internalized behaviors, psychological distress, affect regulation).
4. Parent-Child Relationship (e.g., quality of attachment, parenting capacity, parenting practices, caregiver stress).
5. Family Ecology (e.g., life stress, psychological distress, adult trauma and victimization, economic hardship).
6. Complex Trauma (e.g., child maltreatment and neglect, domestic violence, and community).

Application of the IDEAA model requires the clinician to view the presenting problem (s) within the context of the child's diverse ecological systems, with particular emphasis on the microsystem (e.g., child, caregiver, family, peers, and school). Thus, assessment may include the parents, appropriate family members, and social agents involved with the child. The IDEAA model was NOT informed by research on adolescents, nor intended be used to assess youth 12-years or older, or as an evaluation for sexual aggression or for adjudication for juveniles as sex offenders, or for termination of parental rights or custody determinations. Specifically, the IDEAA model aims to address the following types of inquiries:

- Can the child's sexual behavior be considered within a typical developmental context rather than as maladaptive or dysfunctional?
- How does the child's behavior compare with sociocultural standards of "normal?"
- What is the context for how the concerning behavior is viewed as abnormal and concerning?

- Is there concern or evidence of possible exposure of the child to trauma, neglect, or abuse; consider the individual child, siblings, parents, family, peers, and community?
- What is the level of functioning of the developing child?
- Are there behavioral, psychological, or social-emotional issues that may contribute to the child's concerning behaviors?
- What elements within the parent-child relationship and the family system may contribute to the development, intensity, frequency, and duration of the childhood sexual behavior?
- What adverse factors influencing the parent and family may affect the caregiver's capacity to parent, cope, and support the developing child?
- What is the quality of the relationship and attachment between the child and parent(s) and family?
- What wide-ranging environmental influences (e.g., school, neighborhood, national or global events) may contribute to life stress for the child and family?
- What potentiating risk factors may contribute to the child's problematic sexual behavior?
- What compensatory or protective factors exist within the child and family's diverse ecological systems that may be enhanced to support them?
- How might safety and supervision for the child and others involved be established when such concerns exist?

The IDEAA model offers a collaborative, transparent approach to assessment that encourages a dialogue between the clinician, family, child (when developmentally appropriate), and any involved adults to promote an ecological response to the presenting problematic behaviors. The clinical assessment process of the IDEAA model potentially becomes an intervention due to the involvement and psycho-educational dialogue that occurs throughout the assessment process. Outcomes from the assessment process intend to yield results for the following inquiries:

- How can parents, teachers, and other concerned adults respond to the concerning childhood sexual behaviors in a respectful, responsible, and non-stigmatizing manner?
- What relevant treatment goals and intervention strategies may be necessary to address the presenting concerns related to the childhood sexual behavior?
- How might concerned adults support implementation of strategies and interventions to reduce the problematic sexual behaviors and enhance the child, parent, and family's functioning, in a non-stigmatizing or harmful manner?

The overall process of the IDEAA model follows a common approach to clinical assessment with children. Throughout the clinical assessment process, the clinician's role is to gauge the nature of concerns surrounding a child's sexual behavior. As well as evaluate how the child is functioning within their home and community, how the caregiver(s) are functioning and managing the child's behaviors, and ultimately discern what dynamics might be contributing to the child's concerning sexual behaviors.

Clinicians are reminded that throughout the assessment process should a child disclose any type of exploitation, abuse, or neglect or should any concerns arise of the possible abuse of a child or vulnerable adult, the clinician must report their concerns to an investigating agency. In accordance with State laws, professional licensure and ethical guidelines of practice, a mandated report must be completed to law enforcement or child protection services.

All referrals are screened for third party involvement with agencies such as child welfare services or law enforcement, due to the potential investigation of sexual abuse. If there is a third-party referral rather than a direct referral from a parental guardian, then an introductory planning meeting occurs with the third-party referent and parents to clarify the referring questions and concerns, as well as, identify all involved parties who represent various social and family agents involved with the child of concern. These might include teachers, therapists, medical providers, Court Appointed Special Advocates, and other relevant professionals or involved adults.

The clinician will also review the expectations and ecological approach for the assessment process, review and request consent for the assessment along with review of all confidentiality, privacy practices, and permission to exchange information with other parties involved with the child and family. The clinician will explain that at the end of the assessment period, before the final report, a feedback session is scheduled between the caregiver(s) and referent if different, along with relevant involved providers, to discuss the assessment outcomes and to formulate recommendations through a collaborative team process. This further develops an ecological system of support for the child and family beyond the assessment process. Following the feedback session, the

formal report is completed and distributed to the referent, parent, and designated parties on the team who will continue to provide systems of support for the child and family.

If there is no third party involvement, the planning meeting occurs during the first meeting with the parental caregivers. If the parental caregivers are from different households and are unable for safety reasons to attend together then separate meetings may be coordinated with the clinician. This initial meeting is an important opportunity to build a positive rapport with the parents and involved parties with intention of collaborating in a transparent manner to discover details and answers to questions related to the presenting concerns for their child and family.

The IDEAA model necessitates multiple sessions with the parenting caregivers and the child, as well as other involved adults. The total number of sessions for the assessment process varies depending upon the number of involved parental caregivers (e.g., divorced parents, biological parents and foster parents), family members, and involved community professionals or service providers.

Following the introductory meeting, the parenting caregiver(s) meet without the child for a clinical intake session. In a continued effort to establish rapport, time is spent clarifying any questions regarding the assessment process and intentions particularly related to any third-party involvement. The clinical interview is completed with the parent providing information for the history and context of the child's presenting concerns. Any standardized tools or assessment inventories may be administered at the intake session. However, it is often helpful to schedule a separate session to complete any assessment measures; the initial meeting can be overwhelming and may not yield

accurate responses from self-reported measures if the parent feels stressed or overcome by information and discussion from the clinical interview.

Various methods, assessment tools, and techniques may be applied throughout the process of the IDEAA model. Standardized measures or testing instruments play an important role in assessment. The use of standardized tools potentially provides a mechanism for identification of strengths and deficits in a particular realm of functioning, as related to the individual, compared to standard norms of functioning reflected among broader society (Gilgun, 2003; Groth-Marnet, 2003). They may aid in formulating a diagnosis and treatment plans, may help estimate progress in treatment, and may provide measures of outcome and data that may demonstrate effects of treatment (Gilgun, 2003).

Use of standardized measures or testing instruments with children often relies on caregiver reports rather than self-reports due to the age and development of the child. Keep in mind, the reliability and validity of the information provided may be in question depending on the state of mind and functioning of the reporter, and their factual knowledge of the child. An adult's beliefs, psychological distress, impaired attachment to the child, and other factors of influence may obstruct the reliability and validity of their perspective on accounts of their child's behaviors and intentions. Despite the limitations of self-reported assessment tools, testing instruments are quite useful in assessment when used in conjunction with other tools, collateral information, and direct observations.

IDEAA utilizes clinical methods and standardized testing instruments as features of the assessment process. Implementation of the IDEAA model requires the clinician to conceive the process from an integrated framework utilizing the six-components of assessment referenced in Figure 11 and detailed in the next chapter.

Six-Component Assessment Design

Details of the purpose and intention for each designated component of the IDEAA model described in this chapter include a sample procedure. It is important to remember that the IDEAA model identifies components included in the assessment design; yet this ecological approach to assessment involves a collaborative *process* that is equally relevant to the specific components and outcomes of the assessment. The collaborative process involves individuals from various ecological environments that interact with the child and family system. The IDEAA model, built upon the belief that there is value in the process across time and with the interactions between parties involved with the child, which potentially produce a rich understanding of the ecology of the child, family and community. Such a process intends to result in the identification and emergence of community-based supports that evolve from the process, which serves to provide beneficial and protective factors for the child and family.

Bio-Ecological Development

Bio-Ecological Development represents the biological and developmental influences and functioning of a child. Factors of influence encompassed in this component as noted in the resulting sub-themes, Child: Biological Factors and Sociocultural Influence, include age, stage of development, cognition, physical health and vulnerabilities, as well as a child's race, ethnicity and the sociocultural context of their family ecology and expectations of the child. When assessing a child's sexual behavior, the starting point is understanding a child from a holistic and ecological viewpoint is essential for comprehending the context of a child's behaviors. Command of knowledge and comprehension of developmental theory, developmental stages and milestones, and

developmental expectations are essential for any clinician evaluating a child. Gathering information about a child's biological or physical development assists the clinician in formulating a hypothesis of the child's current level of functioning; thereby assisting to form an accurate picture of where the child's abilities place them along the continuum of child development.

Specific information regarding any previously identified developmental delays is particularly relevant. Areas of potential delay might include communication or language skills, cognitive skills, gross and fine motor skills, sensory processing and regulation skills, vision or hearing, and neurological concerns or other medical conditions. When accessing such information, particularly when requesting records or reports, the clinician must be mindful of the timing of the evaluative report requested and whether the information is pertinent to the child at the time of the current clinical assessment.

Although psychological and social-emotional development are intertwined with a child's biological development, these are addressed specifically within the Psychosocial Emotional Development component of the assessment, discussed later in this chapter. Children with delays in one area of their development commonly are challenged in other areas as well. For example, a child with compromised hearing may also be delayed in communication skills, which may result in difficulties in school and with peers. A child who may feel unheard and unable to communicate effectively may resort to more aggressive or externalized behaviors in an attempt to get their needs met. This may result in rejection by peers that manifests into poor self-concept and low self-esteem. Another example is a child challenged with sensory integration and communication may be sensory-seeking and touch its own genitals during stressful times at school or home as a

method of soothing or affect regulation. Once understood this may provide context for why the child touches its own genitals, which then seems reasonable and normal versus maladaptive and problematic.

Biological factors may also represent vulnerability of a child due to developmental delays or other risk factors of influences. For example, a young child without expressive language skills is likely more at-risk than a child capable of communicating. In addition, young children are dependent on their caregivers in a variety of ways and have little means to exit a situation that may be volatile, abusive, or neglectful. Children under age six are less likely to attend school where they have access to other adults and resources. These examples illustrate ways that biological factors can be risk factors resulting in increased vulnerability.

Applying each component in the IDEAA model as a template can aid the clinician in developing a comprehensive view of the child within their various ecological environments (i.e., home, school, neighborhood, and community). The result is a conceptual framework for identifying realistic and relevant expectations for the child and their behaviors.

Sample procedure. The Behavior Assessment System for Children, Second Edition, Structured Developmental History (BASC-2 SDH) (Reynolds & Kamphaus, 2006) provides a mechanism to obtain biological and developmental information. This tool serves as a means to gather information across various developmental domains directly from the caregiving parent. When more than one set of parent's are involved it is often beneficial to complete a clinical interview utilizing the BASC-2 SDH with each

parent in an effort to capture a comprehensive vision of the child along with the perspective of each reporting parent.

Collateral contacts, communicating directly with the adult provider currently involved with the child, can be quite informative and beneficial. Review of relevant medical records, evaluation, or progress reports from involved practitioners might include a speech therapist, occupational therapist, medical specialists, psychiatrist, mental health counselor, school psychologist, or special education services. When there are wide discrepancies in reported information from differing sources, these become avenues for follow-up and additionally offer perspective on how that specific reporter perceives the child. This is particularly meaningful when there is broad range of opinions between caregivers within the home, or between adults in two settings such as school and home.

If a child and family are involved with a child welfare social service agency or adoption services, and reside in out-of-home placement such as kinship care or foster care, gathering records from the involved social service worker is critical in order to have a complete picture of the child. Foster or kinship care providers may have limited or no information on the child's developmental or medical history. Extra effort and time may be necessary to gain access to this information. However, typically, the social service worker will have a comprehensive document of a child's medical records and a service plan addressing the child's removal from their home, family history, and involvement with the child welfare or adoption agency.

In addition to record review, developmental history-taking, and collateral contacts, an individual session is arranged between the clinician and child. Session length is adapted to the age and attention span of the child; but typically, ranges from

30-60 minutes. More than one session can occur as necessary. The child-session offers opportunities for engagement and screening of the child's developmental skills, with a chance to observe the child during play while attending to various tasks. The clinician may use a variety of projective techniques or direct or non-direct play therapy techniques to engage the child during the session.

Projective techniques and drawings have gained acceptance and continuous clinical use diagnostic and clinical aids (Dileo, 1973; Piperno, Di Biasi, & Levi, 2007; Veltman & Browne, 2000; Wasserman, 2003). Examples of projective techniques include the Favorite-Kind-of Day (Veltman & Browne, 2000), Draw-a-Person (Goodenough, 1926), House-Tree-Person (Buck, 1948; Buck & Warren, 1992), Draw-A-Family and Kinetic Family Drawings (Burns & Kaufman, 1970). These varied projective techniques, including Sentence Completion, are effective as mechanisms for rapport building and gaining awareness of a child's developmental capacities and perspectives (Piperno et al., 2007; Veltman & Browne, 2002; Wasserman, 2003; M. Reid, personal communication, January 20, 2007).

Sentence completion techniques, for example, work well providing respondents with a narrative prompt or "stem" to engage the child while exploring various aspects of the child's feelings, thoughts, motivations or uncovering conflicted attitudes (Lawrence & Smith, 2008; M. Reid, personal communication, January 20, 2007). While rapport is established, the clinician can begin to inquire about the child's family, friends, school, and neighborhood, using open-ended questions stated in developmentally appropriate language. The intention of the child-session is to engage the child while screening developmental functioning and building rapport to inquire about safety and safe

boundaries. Open-ended questions provide an invitation for the child to disclose safety concerns, as well as, offer an opportunity for intervention with the child by introducing safety skill building with the child.

Outcomes from review of the developmental history taking, review of collateral records and contacts, coupled with the child-session offer a bio-ecological view of a child's stage of development and current functioning. The next component involves the assessment of the child's sexuality, sexual development, and sexual influences. This component labeled Child Sexuality is an essential aspect of the assessment that may determine whether or not the child warrants interventions, and if so to determine concerns specific to safety, such as supervision or possible removal from the home or environments with younger children.

Child Sexuality

The component Child Sexuality attends to aspects related to sexuality and sexual development drawn from the literature review and analysis in this study, specifically the core theme Child Sexuality: Ecological Context that includes sub-themes Child Sexual Development and Sociocultural Influences, and related concepts. Exposure to sexual content and media, modeling of sexuality, family sexuality, socialization, and sexual experimentation with peers are all associated with child sexual development and sexual behaviors.

Sexual development is a normal, typical aspect of human development that matures over time but begins during infancy. As previously reviewed, there are wide ranging beliefs about what constitutes normal child sexual behavior. Results suggest that sociocultural beliefs and values shape the standards of what constitutes as normal or

appropriate childhood sexual behavior. The lack of consensus on what is normal reflects a broad range of opinions and beliefs on the subject. Typically, adults interpret problematic child sexual behaviors as those that mimic mature sexual knowledge and activity, such as imitating or attempting sexual intercourse with another child, inserting objects into one's own genitals, or another child's genitals; or oral-genital contact (Friedrich, 1993; Friedrich et al., 1992).

There is an unfortunate lack of contemporary research on childhood sexual behavior representative of the 21st century United States, which is a modern society that yields prolific exposure of sexual content and media to children of all ages. Thus, it seems increasingly more complex to discern the range of normal or maladaptive childhood sexual behavior, as the scope of exposure to sexual content and media within family and social environments has broadened.

Despite the absence of information and lack of consensus on the limits of childhood sexual behavior, there are some parameters from published literature that attempt to define sexual behaviors deemed problematic. Child sexual behavior problems often involve aggression, harm, coercion, and/or distress, and therefore require intervention. Behaviors that result in harm to the child or other children need attention and intervention that may differ from behaviors perceived as problematic that do not result in harm. Consequently, it is important to gather details and clarify the nature and context of a child's concerning sexual behavior, within their family and social environments, before defining the behavior as a sexual behavior problem.

Sample procedure. Clarifying the details and context of the child's concerning sexual behavior is a critical aspect of this component. Initially information gleaned through a dialogue with the parent about the details of the child's sexual behaviors must include specific details of the concerning behavior, as well as, the frequency, intensity and duration of the sexual behaviors. The clinician will be the most effective communicating with the parent if they are knowledgeable and comfortable discussing, sexuality, sexual behaviors and anatomy. Familiarity with current research and knowledge about sexual development and child sexual behavior is also beneficial and affords the opportunity for educating the parents and involved adults. It is equally important to understand the limitations of the research and to maintain an open view of child sexual behavior from a contextual perspective, while recognizing one's own biases and beliefs toward child sexuality and sexual behavior.

Initial reports of child sexual behavior are often incomplete and may be inaccurate. Based upon 15 years of clinical experience, it was common for adults (i.e., caregivers, grandparents, babysitters, school personnel) to report concerning child sexual behavior based upon what they assumed occurred, rather than report the exact behavior observed. Clinicians need to ask for details of exactly what was observed or heard by the reporting adult rather than what the adult assumed, implied, or interpreted about the behavior. This is a critical aspect of the assessment process.

Listening for the caregiver or parent's concerns about possible sexual abuse, or fearful reactions that their child may grow up to be a sex offender, is important and requires a response. In some instances, the reporting adult sexually abused as a child may over or under report the sexual behavior of the child due to their own history of

victimization. Regardless, if the caregiver reports the child was sexually abused then details of that information are important to note. Specifically, when did the abuse allegedly occur, who was the perpetrator and what is the current location of the perpetrator; as well as, whether or not the sexual abuse was reported and/or investigated by law enforcement or CPS, and did the child or family receive any treatment or services.

Although child sexual behavior is no longer considered diagnostic for sexual abuse, and occurs due to a multiplicity of influences, research indicates that children sexually victimized display problematic sexual behavior with greater frequency (Heiman et al., 1998). Thus, there continue to be children abused sexually who exhibit concerning sexual behaviors. Clinicians need to make a concerted attempt to assess the possibility of sexual abuse when a child presents for assessment. If a child makes a disclosure of sexual abuse or any form of maltreatment or neglect, then a mandated report of the alleged abuse must be made to an investigating agency. It is strongly recommended that a clinician inexperienced with assessment of child abuse receive consultation with an appropriate experienced professional, or refer the child to a trained child interviewer, prior to attempting to interview the child about the alleged abuse.

While gathering details on a child's sexual behaviors, the context of the behavior is relevant, including any atypical occurrences or changes within the child's microsystem that may correlate with the onset of the behavior. Child sexual behavior has been associated with family sexuality, exposure to sexually explicit content and adult sexual behaviors; thus, changes within the immediate environment might include a new television, computer, iPod or cellular-smart phone or iPod with Internet access in the home, or a new teenager or adult in the home viewing mature content. Perhaps the

primary caregiver has recently been preoccupied with a new job and has less time to supervise the child. This may equate to the child, perhaps inadvertently, viewing sexually explicit material in the form of movies, video games, and social media on the Internet. Access to sexually explicit material is quite easy and readily available to individuals of all ages. Depending on the age and development of the child, the noted sexual behavior may correlate with the sexual content observed by the child. Ultimately, it is important to consider the potential influential factors and risks related to a child presenting for assessment.

In addition to the clinical interview and dialogue regarding the child's sexual behaviors, projective techniques, such as those previously mentioned, and exercises on values, feelings, and attitudes around sex/sexuality may be useful during the child-session (T. C. Johnson, presentation, January 28, 2007). Another beneficial assessment tool is *The Family Sexuality Index* (Friedrich, 2007), offers a useful instrument to assess the level of explicit sexuality in the child's home. The 17-item instrument associates higher positive scores with childhood sexual behavior considered problematic. This tool is limited as it is a parent or family members' report; however, it is a useful for clinicians in gathering specific information on the culture and practices regarding sexuality within the ecology of the family.

The instrument is available in Friedrich's book, published posthumously, *Children with Sexual Behavior Problems: Family-Based, Attachment-Focused Therapy* (2007) and contains another useful assessment tool named the *Safety Checklist*. This assessment tool is a semi-structured interview, which contains a variety of questions posed to the caregiver specifically related to sexuality (e.g., family nudity, sexually

explicit content, co-sleeping, and co-bathing). This tool assists with the inquiry related to the child's potential exposure to mature sexual behavior, information, and explicit material. Use of these tools provides opportunities for psycho-education and identification of potential risk and protective factors within the home and immediate environment. This is an example within the IDEAA model where the assessment process may function as a form of intervention for the child and family.

Another instrument related to childhood sexual behavior is the CSBI, (Friedrich, 1997). As reviewed and discussed earlier the CSBI is the only standardized instrument created to assess sexual behaviors in male and female children between the ages of two to 12-years old. Results from the CSBI instrument provide three subscale scores intended to differentiate developmentally related sexual behaviors (DRSB) from sexual abuse specific items (SASI), and a total CSBI score. The DRSB subscale score relate to behaviors commonly considered developmental. High SASI scores were considered more likely to relate to sexual abuse; however, high SASI scores are not diagnostic of sexual abuse; nor should results of the CSBI solely be used to diagnose sexual abuse (Friedrich, 1997).

Concerns exist among professionals in the field that the CSBI may no longer be valid and reliable. Reasons for concern include significant cultural changes since the inception of the instrument, such as advancements in technology (e.g., Internet, social networking, video and computer games) and the widespread dissemination of sexually explicit media. As well as, the lack of representation in the normed sample of non-White children and absence of caregiving fathers represented in the caregiver-reported sample population.

Despite the limitations, this instrument applied in countless research studies and clinical settings offers some utility and application when used with caution and acknowledgment of the limitations. Clinical application suggests this 38-item instrument has value as a starting point for gathering details of very explicit sexual behavior by a child observed by the caregiver. Utilizing the CSBI offers an opportunity to expand dialogue with the caregiver about the child's sexual behavior, and affords a potential perspective of how the child's behavior compares with same aged, same gendered, White children.

It is possible, that following completion of the clinical interview parent-session and the initial team meeting and discussion, that it may be apparent the child is not acting out sexually in a maladaptive or problematic way. It may become apparent that it is the caregiver, or referent, and not the child who needs education about child sexuality, child development, behavior management techniques, or other forms of support.

Results from the clinical interview parent-session and child-session, plus any assessment tool results, and collateral records or information collectively offer a comprehensive view of Child Sexuality. The next component in the assessment process involves another dimension of child development strongly linked with the ecology of the family and associated with childhood sexual behavior problems, labeled Psychosocial Emotional Development.

Psychosocial Emotional Development

This component incorporates elements of child development that may increase vulnerability and risk potential for a child, such as, emotion regulation, interpersonal skills, externalized and internalized behavior problems, emotional distress, and

post-traumatic stress. These reflect results related to childhood sexual behavior problems associated with the sub-theme, Psychosocial & Emotional Distress, encompassed within the core theme Complex Trauma. Children affected by trauma in the home or community, whether by neglect, physical, sexual, or emotional abuse, exposure to domestic or community violence, are vulnerable in a variety of ways. Commonly the impact of abuse on a child has a potential lasting impact on the overall development of the child.

Frequently children with emotion regulation problems are also those who exhibit externalizing behaviors, and sexual behavior is an externalized behavior (Friedrich & Trane, 2002). Specifically in relation to children exhibiting sexual behavior problems, symptoms of PTSD and regulatory disorders have been associated with more severe sexual behavior problems (Friedrich & Trane, 2002; Hall et al., 2002; Pithers et al., 1998). Other research studies suggest children with sexual behavior problems were more likely to exhibit externalized and internalized behavior problems such as ADHD, oppositional or aggressive behaviors, depression, anxiety, and PTSD (Bonner et al., 1999; Friedrich et al., 1991, 1992; Chaffin et al., 2008; L. A. Rasmussen, 1999, 2004). Careful assessment of a child's social, emotional, psychological, and behavioral functioning, along with assessment of sexual behaviors, is necessary. Consequently helping to clarify and prioritize attention to the presenting concerns, and for designing interventions to improve the overall adaptive functioning of the child within diverse ecological settings such as home, school, and community settings. In some cases, addressing childhood sexual behaviors may not be the top priority as other presenting problems may take precedence.

Sample procedure. Assessment related to the component Psychosocial Emotional Development overlaps with other components of the IDEAA model, which is consistent with ecological systems, and the ecology of child development. Assessment related to this component occurs with the initial parent-session and administration of the BASC-2 SDH. Retaining collateral records, and contact with involved providers from the community, school and/or childcare regarding any relevant areas of concern identified during administration of the BASC-2 SDH will aid in creating a complete picture of the child's needs and strengths. It is specifically within this component that indicators and symptoms of child trauma and maltreatment may emerge. Caregivers may be reluctant to disclose if their child was abused, particularly within the immediate family system, therefore, administration of standardized instruments can be quite useful in discerning the potential influences of trauma, or other emotional or behavioral disturbances or distress.

One example of a selected instrument available for children specifically for the assessment of trauma-related symptoms is the Trauma Symptom Checklist for Young Children (TSCYC) (Briere, 2005). This is a 90-item caregiver-report instrument developed for the assessment of trauma-related symptoms in children as young as three years old. Scales include two caregiver report validity scales, as well as a norm-referenced item that evaluates how many hours a week the caregiver spends with the child. The TSCYC generates a likely diagnosis of PTSD, with acceptable sensitivity and specificity (Briere, 2005). TSCYC scales were reported as reliable and predictive of a child exposed to sexual abuse, physical abuse, and witnessing domestic violence (Briere et al., 2001).

The alternate version available for children 8-to-16 years old is a self-report instrument called the Trauma Symptom Checklist for Children (TSCC) (Briere, 1996). It is a 54-item self-report measure to evaluate post-traumatic symptomatology in children and adolescents including the effects of child abuse and neglect, other interpersonal violence, witnessing trauma to others, major accidents, and disasters (Briere, 1996). This measure has two validity scales, as well as six clinical scales. The TSCC demonstrated as reliable and valid in various studies of traumatized children and adolescents (Briere, 1996). Whereas the TSCYC relies on the caregiver-report, the TSCC was written at a level designed to be understood by children eight years of age or older. Administration of both versions of the trauma instrument, when age appropriate, may yield relevant and interesting data in terms of the similarities and differences in how the child and primary caregiver respond to the questions.

Another useful instrument for assessing child behavior and adaptive functioning is the Child Behavior Checklist (CBCL) (Achenbach, 1991). The CBCL is an instrument used to assess competencies, adaptive functioning, and problems in children ages one and a half to 18 years old. There is a Language Development Survey for children one and a half to three years old that aids in detection of communication delays (Achenbach, 1991). The CBCL provides a standardized means to evaluate the range of a child's behaviors in terms of adaptive or maladaptive functioning (Achenbach, 1991). The CBCL provides specific data related to an array of behavioral and emotional problems, specifically externalized and internalized behaviors, which have particular relevance when evaluating childhood sexual behavior problems. Identification of these potential concerns provides

insight into the overall functioning of the child and thus provides guidance for appropriate treatment goals and intervention strategies.

All profiles provide specific subscales called Syndrome Profiles and Diagnostic Statistical Manual (DSM) - Oriented Scales, including a Sex Problems syndrome scale, although it only exists on the caregiver rating form. The subscales assist the clinician in identifying the relationships between reported behaviors and their representation as clusters of possible specific syndromes or psychological disorders related to the DSM (Achenbach & Rescorla, 2000, 2001). The CBCL provides data that relates specifically to child development, academic performance, and social competence, and informs functioning related to adaptive, psychological, behavioral, and social competence.

The CBCL assessment offers a caregiver-reported form, a teacher-rated, and self-reported form for youth eight years and older. The CBCL may be completed by multiple adults who interact with the child in a variety of settings outside of the immediate home environment (e.g., school, extended family, or childcare settings). Multiple informants from diverse settings offer an ecological perspective of a child's functioning in various ecological contexts. The scoring forms, whether hand or computer scored, provide multiple informant comparisons of the results. This can be quite beneficial as a comprehensive way to compare observations about the child's social, emotional, developmental, and behavioral functioning. This process offers another form of intervention and education as adults gain perspective of the child's functioning across settings, compared to same-aged, same-gendered peers. Caregivers may experience relief in understanding their child from a developmental perspective across diverse ecological contexts, aiding in construction of a holistic vision of the child.

Results from the testing instruments and information from the clinical intake parent-session, and the child-session, coupled with any collateral records and contacts, provide a comprehensive view of Psychosocial Emotional Development as related to the IDEAA model.

Parent-Child Relationship

The Parent-Child Relationship component of the IDEAA model specifically addresses the significance of the quality of attachment, parenting style, caregiver stress, and parental capacity to cope. These elements are highly associated with the resulting sub-theme, Parenting Capacity, encompassed within the major theme, Developmental Context.

During infancy and early formative years, the parent-child relationship is viewed as the cornerstone for establishing a child's sense of trust and security in the world. This relationship has profound influence on the child developmentally and deserves attention. Not surprising it appears that families of children with sexual behavior problems commonly are families with relational problems (Friedrich & Luecke, 1988).

Assessing the quality of the parent-child relationship helps to formulate understanding of how a child presents within the world. For example, a child with disrupted attachment may exhibit greater difficulties trusting adults and feeling safe. This may evolve into difficulties in establishing relationships and regulating emotions due to an innate sense of insecurity and distrust. In contrast, healthy attachment and a nurturing, positive relationship with a parental caregiver functions as a protective factor that enhances a child's ability to develop and function (Donald & Jureidini, 2004).

In some situations, the parent involved in the assessment may not be the biological mother or father. In situations when the primary parent is absent, then information about that primary relationship, and whether or not there were concerns related to attachment or poor parenting is quite relevant for understanding the child. If there has been a disrupted attachment complicated by grief and loss due to removal from their family or termination of parental rights, this likely has significant impact upon the child in multiple domains of development (Donald & Jureidini, 2004). Such disruption is viewed as traumatic and often results from a hostile family environment and may be complicated by other adverse factors such as neglect or maltreatment. These dynamics will be discussed later in the chapter in the components of Family Ecology and Complex Trauma.

Other aspects related to the parent-child relationship involve parenting practices and a caregiver's capacity to parent. There may be multiple reasons why a caregiver may be limited in their capacity to parent (e.g., mental illness, life stress, domestic violence, substance abuse, education level, and adult trauma) (Donald & Jureidini, 2004). The results from this study, coupled with clinical experience, strongly suggest that mothers of children with sexual behavior problems appear to be victims of trauma with ongoing symptoms of disturbance that interfere with parental functioning (Hall et al., 1998; Lovejoy et al., 2000). Some parents may simply need more education and training regarding developmentally appropriate parenting practices. Identifying these factors helps to reveal potential risks and strengths of the parental caregiver along with prospective interventions and resources of support.

Sample procedure. Additional sessions with the parents, beyond the initial session, may be necessary to develop adequate rapport with the parents to exchange information necessary to evaluate the parent-child relationship.

Administration of the Beck Depression Inventory - II (BDI-II) (Beck, Brown, & Steer, 1996) serves as an indicator of the occurrence and severity of symptoms of depression in adults; the BDI-II is specifically designed to address DSM criteria for depression. This instrument, easily administered in 5-10 minutes, assists in providing a gauge of the primary caregiver's current level of depression (Beck et al., 1996). When possible, administration of the BDI-II during the initial intake session is preferred for establishing a current baseline for evaluating depression in the parent at the onset of the assessment and prior to completing any testing instruments. Elevated symptoms of depression may affect caregiver's, in particular a maternal caregiver's, view of the world including their perspective of and feelings toward their child (Lovejoy et al., 2000; Petterson & Albers, 2001; Youngstrom, Izard, & Ackerman, 1999). It has been suggested that symptoms of depression that are severe enough may affect an individual in various ways (e.g., sleep, appetite, irritability and mood, motivation, and negativity) and depression has been noted to interfere with individual functioning. Screening for depression provides insight and opportunity for potential intervention with the parent on behalf of the child. All caregivers involved in the assessment process should complete the BDI-II when possible due to its potential effect on the assessment process and caregiver's capacity to parent.

Another useful testing tool is the administration of the Parenting Stress Index – Long Form (PSI) (Abidin, 1995). This is a parent self-reported instrument designed to measure the relative degree of stress in the parent-child relationship, how well the parent and child reinforce one another, and identifies potential sources of distress. The PSI also identifies children with behavior and emotional problems and parents who are at risk for dysfunctional caregiving. The PSI consists of 120 items and takes less than 30 minutes to complete. Results indicate a Total Stress Score and scale scores for Child and Parent Characteristics, which aid in identifying sources of stress within the family system. The Parent results are measured in seven subscales: Competence, Isolation, Attachment, Health, Role Restriction, Depression and Spouse. The PSI was empirically validated to predict parenting behavior and children's behavioral and emotional adjustment, with various populations from North America and international populations.

If a child is involved with a child welfare agency or adoption services, or in an out-of-home placement, then speaking with a professional at the child welfare office is necessary to gain background information about the parent-child relationship, prior to the child's removal from their home. In some circumstances, it may be necessary to involve the biological parent(s) in the assessment process particularly if the child's service plan is to return to the biological home.

Results from these testing instruments and information from the clinical intake and follow-up parent sessions, coupled with any collateral records and contacts, offers a comprehensive view of the Parent-Child Relationship component of the IDEAA model.

Family Ecology

Results indicate that children exhibiting problematic sexual behaviors are highly associated with concepts within the sub-theme Complex Family Dynamics. Specifically, families that experience economic hardship, fewer educational resources, and high levels of life stress have been associated with children with sexual behavior problems. The family unit sits at the heart of the microsystem in which the child is deeply embedded; therefore, it might be anticipated that family adversity is a strong predictor of childhood sexual behavior problems. Dynamics within the family ecology such as psychological distress, adult trauma, family perpetrators and generational abuse, as well as the child's removal from the home are all associated with childhood sexual behavior problems. An array of reasons exists why a family may be experiencing distress that compound into a dysfunctional and toxic family system. It is important to consider the stress felt by a family when their child exhibits sexual behavior problems, particularly when the child acts out with a younger child in the home, is expelled from school, or perhaps CPS gets involved. Now an already strained family system may become even more distressed.

The IDEAA model intends to prioritize the safety and well-being of the entire family system. As necessary, psycho-education and coping strategies may need interjected into the family through the parent, to help retain some stability and establish safety. Often the adverse factors affecting the family may extend far beyond the immediate environment and may reflect broader social or cultural issues, like economic recession or immigration concerns.

Whatever the factors may be, gaining a comprehensive view of the family dynamics is necessary for establishing treatment goals and recommendations. Engaging the family in the assessment process for their child's sexual behavior concerns may contribute to better outcomes for the child and family. Findings from this study, specifically related within the sub-theme, Effective Treatment, found that successful outcomes in treatment directly relate to caregiver participation and parent management training.

Sample procedure. Assessing the functioning of the family ecology and potential aspects of adverse family dynamics can be accomplished as part of the initial intake parent-session, BASC-SDH interview, and follow-up sessions. Establishing a welcoming and compassionate atmosphere when engaging with the parent may help reduce the stress and fear associated with the assessment process, particularly if any social welfare, legal, or community agencies are involved. In spite of the fact that assessment is intended to be helpful; the experience and circumstances around the referral for the assessment may result in some initial resistance or defensiveness from the parent and family.

The PSI also offers relevant information related to Family Ecology, specifically identifying life stress and parenting dynamics that interfere with or fail to promote positive child development and functioning. This tool can be administered to all the caregivers responsible for parenting the child. Information gleaned from the Safety Checklist offers additional insight into the dynamics of Family Ecology that may represent as risk or protective factors. Results from the PSI, BDI-II, Safety Checklist, parent-sessions, and collateral records and contacts, collectively provide context for the

ecology and functioning of the family system, and the potential affect upon the child and their behaviors. These outcomes offer a comprehensive view of the Family Ecology component of the IDEAA model.

Complex Trauma

Although Complex Trauma is a potential element of the component Family Ecology, it was identified as a separate component due to its strength as a predictive factor related to childhood sexual behavior problems. Results captured in the major theme Complex Trauma and sub-theme Child Maltreatment & Trauma strongly suggest that elements of oppression related to exposure to domestic violence, physical, sexual, and emotional abuse, and neglect were highly associated with children exhibiting problematic sexual behavior. Familial caregivers modeling behaviors of force and control likely reinforce and inadvertently encourage aggressive and coercive behavior from their child. Thus, it is not surprising that children parented by physically or emotionally abusive caregivers were found to exhibit sexual behaviors that involved another child or person (Hall et al., 1998).

Analysis resulted in a clear and consistent association between child maltreatment and trauma with childhood sexual behavior problems. The effects of maltreatment and prolonged exposure to abuse, neglect and other forms of violence and trauma significantly influence child development and functioning across multiple domains.

Sample procedure. The primary method of assessment for this component includes the intake interviews, parent-sessions, results from the PSI offer clues about the level of stress in the home, and results of the TSCC or TSCYC and CBCL reflect potential trauma symptoms and level of adaptive functioning. Completion of the Safety

Checklist semi-structured interview with the parent and relevant family members assists in determining whether there are adverse circumstances or safety concerns affecting the child and family. On one level, this helps to establish safety as a priority for everyone, while simultaneously identifying potential points of intervention and assistance for the family system. This dialogue provides another intervention opportunity for psycho-education and rapport building between the parents and involved family members. Should concerns of safety arise for the parent or child then a mandated report to either child protection services or law enforcement must be completed in accordance with local and state laws.

Results from previous testing instruments and information from the clinical parent-sessions, the child session, coupled with any collateral records and contacts, offers a comprehensive view of the Complex Trauma component of the IDEAA model.

Conceptualization and Collaborative Feedback Session

Once the assessment measures, parent and child sessions, and collateral contacts are complete, the clinician must analyze the results and synthesize the information within an ecological conceptualization using the IDEAA six-component model as a template. It is suggested that preliminary hypotheses are generated related to the child's behavior and functioning including the parent's relationship to the child and capacity to effectively parent the child, and then the clinician is ready to schedule a collaborative feedback session inviting members of the child's team.

Convening a team meeting in the form of a collaborative feedback session, on behalf of the child and family, is a culminating step of the IDEAA model. After completion of a preliminary assessment report, a feedback session occurs with attendance

by the referent and parenting caregivers with additional guests invited that are involved with the child and family. These invited guests might include extended family members, teachers, therapists, or social service providers. During this meeting, outcomes of the assessment are reviewed and discussed. Participants have the opportunity to indicate if the information seems accurate and to raise any questions or concerns about the results.

The feedback session intends to provide an opportunity for a collaborative, transparent process to discuss and illuminate the outcomes of the assessment. The original referral question and presenting concerns are clarified, historical data confirmed for accuracy, test results and interpretations explained, and recommendations generated for the child and family system. This final feedback session affords the opportunity to exchange and verify information while offering the opportunity to establish and identify compensatory factors to support the success of the child and family system.

Subsequently, the feedback session becomes a form of intervention on behalf of the child that broadens support to the child, family, and community. Soon after the feedback session, the assessment report is finalized and distributed. A few weeks later a client feedback form is sent to the adults involved with the IDEAA model, in particular the parents and referent, to glean feedback on their experience and whether they would recommend this assessment process to someone else in need in the future.

Limitations and Concluding Implications

Limitations of This Study

This study was a non-experimental, qualitative analysis of narrative content from secondary data, which were source articles of selected peer-reviewed research. This was not a quantitative meta-analysis comparing the empirical and statistical results of each selected study. Nor was it a qualitative meta-analysis, which involves analysis of all aspects of each study and may include mixed methods of analysis. No analysis of statistical results from the selected articles reviewed in this study occurred. Each empirical article reviewed innately had its own potential limitations due to the design, methods, and participants in each study. Such limitations have implications related to the validity and credibility of each study's design and findings. I believed that a meta-analysis, although relevant to empirical research, would not bring forth the cultural context of the emerging thematic information I was seeking from this theoretical-conceptual research. Therefore, the secondary data analyzed for this study was comprised of the literature review, interpretation, discussion, and conclusion sections constructed by the investigators of each source article.

One of the limitations of this qualitative study was the time taken between the conception of the project and the final write-up. Over 120 articles and publications were initially reviewed; inclusion and exclusion criteria were identified for the collection of secondary data source articles, followed by an in-depth thematic analysis of the data. Research published following completion of the secondary data selection process and onset of analysis was not included in this qualitative study. There was almost two years between review of the preliminary literature and completion of the final coding process of the selected source articles. In contrast, the extended time allowed for a thorough review of the literature at the preliminary phase of the study; while during the coding process sufficient time allotted

for contemplation, analysis, and synthesizing of coded categories, themes, and conceptual designs that likely enriched the outcomes and final product.

Moving back and forth through a process of constant comparison, between and within the data, abstracting, and synthesizing within the narrative content of the extant literature was a rich and in-depth experience. Determination of a stopping point results when concepts emerge in a repeated fashion and sufficient themes fit well together resulting in a sense of saturation. Saturation in this study occurred when the overall analysis of data, in relation to the research points of inquiry, were satisfied. This determination may reflect the limitation that there was likely more to glean from the data.

Another limitation is the potential for research bias influencing the findings, as there was only one investigator in this study responsible for the design, selection, coding, and analysis of the data. This investigator throughout the research maintained a clear procedure, rigorous data collection, and strong chain of evidence. Additionally, the design of this study from a social-constructivist epistemology influenced this investigator's input and opinions as a component of the research, continuously captured with notes and at least fifty memos throughout the research process.

Concluding Implications

The goal of any research is to contribute to the fund of knowledge by offering new conceptual material while expanding existing research in the related field. This qualitative study of child sexual behavior problems, specific to children in the United States, included a review of literature that spanned almost thirty years of research. This was an attempt to broaden understanding of this complex issue by expanding the existing body of research, as well as to design a conceptual assessment model for application with children under age twelve in outpatient clinical settings. Outcomes from this research resulted in an expanded,

contemporary conceptualization of childhood sexual behavior problems illustrated in the Ecological Developmental View. Additionally, findings synthesized within the framework of ecological theories, culminated with the introduction of the conceptual six-component IDEAA model.

This non-experimental research can be a precursor to both quantitative and further qualitative exploration of this topic. The findings of this study connect to multiple domains concerning sociocultural, developmental, and ecological aspects of child sexuality and sexual development, child maltreatment and trauma, and childhood sexual behavior problems that point to a variety of potential future research efforts.

Future research might include qualitative studies to confirm and expand the four major themes of Child Sexuality: Ecological Context, Developmental Context, Complex Trauma, and Ecological Interventions and/or the subsequent sub-themes. The conceptualization of childhood sexual behavior problems from an Ecological Developmental View could also be further evaluated utilizing different qualitative methods, such as phenomenology or case study that would undoubtedly result in the expansion of viable knowledge.

There is a clear need for future research specific to biological and developmental factors of influence related to childhood sexuality and sexual development across age, stage, race, ethnicity and gender, specifically within contemporary culture in the 21st century United States. Establishing a normative continuum of sexual behavior reflective of the diversity of children in the United States would offer an empirically informed perspective as to what constitutes maladaptive behavior or problematic sexual behavior.

Design and development of a mechanism to gather and assess self-reported sexual behavior of children would lend important information to understanding sexual behavior from a child's perspective, and specifically what is normal or typical compared with harmful or distressing. It is essential to identify normative sexual behavior and exploration from the child's perspective, rather than solely adult perspectives and parent-rated reports. This would allow for an objective self-report of the child's behaviors absent from the sociocultural influences and perspectives of adults reporting about a child's behaviors.

Distinguishing whether a child's sexual behavior is normal or not has substantial consequences, the replication, and extension of earlier studies from Friedrich and other colleagues would be helpful to define normative childhood sexual behavior. Additionally, there is a lack of current valid and reliable psychometric measures for assessing child sexual behavior. As mentioned previously, the CSBI needs revised and re-normed thus providing a potentially valuable diagnostic tool for clinicians working with children.

Expanding research specific to the effects of the wide range of exposure to media influencing children, adults and communities, as well as the impact on children and sexual behavior and sexuality is another important area for future study.

Future studies examining the developmental and maturational trajectory of childhood sexual behaviors are necessary. Longitudinal research study designs with diverse groups of children in terms of race, ethnicity, age, cognitive development, geographic location, and family variables, would aid in describing the unique experiences of children exhibiting sexual behavior.

The association between ecological systems, child development, and child psychopathology are newly emerging in research specific to childhood sexual behavior problems; additional studies specifically exploring ecological domains of influence would

offer additional knowledge on potential risk and protective factors that could be adapted as interventions for children and families in need.

The IDEAA model designed from the integration of resulting themes from this qualitative study and informed by ecological theories needs evaluated for effectiveness and application. The IDEAA model may provide the basis for a pilot study using a control group to assess the application, utilization, and benefits of the assessment. Furthermore, the IDEAA model might be utilized as a framework for curriculum to educate and train students and clinicians on aspects of child development, child sexuality, the impact of trauma and maltreatment, and childhood sexual behavior from an ecological perspective, which would further expand knowledge on these issues.

The overarching goal of this theoretical-conceptual study was broadening comprehension of childhood sexual behavior from an historical and sociocultural perspective, thereby revealing a contemporary conceptualization of childhood sexual behavior problems. In addition, another intention of the research was determining how extant research informed comprehension and assessment of childhood sexual behavior concerns. Illuminating aspects of childhood sexual behavior problems from both the sociocultural influences and ecological and developmental perspectives aimed to provide a framework for design of a conceptual model for assessment appropriate for use in outpatient clinical settings. Findings hope to stimulate future empirical research that can help inform intervention efforts, and to enlighten and expand understanding of the range and complexity of childhood sexual behavior.

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