Youth Sexuality: An Overview of Factors Related to Problematic Behavior, Risk Assessment, and Treatment

Foster Care Assessment Program

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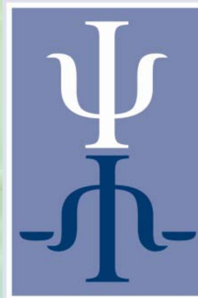

Training Objectives

- Obtain a basic understanding about terminology, prevalence, and etiological hypotheses.
- Achieve a fundamental understanding of reoffense risk and empirically supported risk factors.
- Gain a basic understanding about what is normal and problematic sexual behavior of youth.
- Earn a basic understanding of the assessment and treatment process for youth with sexual behavior problems.
- Achieve a sense of how to supervise and support youth with sexual behavior problems.

Terminology

- TERMINOLOGY:
- SAY = Sexually Aggressive Youth:
  - SAY is a funding source through the Washington Department of Social and Health Services.
- Sex Offender:
  - Some argue that this is only appropriate for those who have been adjudicated for a sexual offense – it is more of a legal term.
- Youth who has sexually abused/Youth with sexual behavior problems:
  - More descriptive and generally accepted as less pejorative.
    - Consider research regarding the relationship between self-esteem and sexual offending (e.g., Monto, Zgourides, & Harris, 1998) as well as the social isolation risk factor.

Prevalence

- Prevalence:
  - Based on data collected between 1991-1996, juveniles account for 23% of all sexual assaults (Snyder, 2000).
  - In 2005, data reported by the FBI Uniform Crime Report revealed that juveniles were responsible for 15.9% of forcible rapes and 19% of all sexual offenses, excluding prostitution – compared to 15.5% for all other crimes (Department of Justice, 2005).
  - Juveniles were responsible for 33% of sexual offenses against all juvenile victims, 39% of sexual offenses against children age 6-11, and 40% of sexual offenses against children age 5 and younger (Snyder, 2000).
  - Females account for approximately 1% of forcible rapes and about 7% of all sex offenses committed by juveniles (Snyder, 2000).

Etiological Hypotheses

- Popular theories of the etiology of adolescent sexual offending behavior:
  - *Family Dysfunction* (e.g., violence, poor boundaries, sexualized atmosphere, poor emotional expression, etc).
  - *Learning Theories* (e.g., Classical Conditioning, Operant Conditioning, Social-Learning).
  - *Physiology* (e.g., cerebral, hormonal, genetic differences).
  - *Socio-Cultural* (e.g., gender imbalances, societal violence, pornography, attitudes toward sex).
  - *Abused-to-Abuser* (data varies here).
  - *Juvenile delinquency* (i.e., nonsexual) models.
  - *Complex **Biopsychosocial** models* (selected elements of those listed above).
    - IT DEPENDS!
      - Adapted from Worling, 2006.

Social/Legal Climate

- Up until last month, sexual offenses were the ONLY juvenile offense that was not eligible for record sealing.
- WA State Sex Offender Registration.
- Adult Risk Assessment tools.
- Polarized perspective of: (a) Predator vs. (b) Childlike.
- Excess of services.
- Lack of scientific understanding of treatment.

Juvenile vs. Adult Sexual Offending

- The distinction between rapists and child sexual abusers that is often applied to adult sex offenders is less appropriate in relation to juveniles who sexually offend (Jones, 2003).

- Compared with adults, adolescents' sexual preferences show a lesser association with their offense histories (Hunter & Lexier, 1998) – their offense types are less likely to reflect their sexual preferences.

- In general, adolescents do not have established, well-developed patterns of sexual interest and sexual arousal (Trivits& Repucci, 2002).

Charges: Penetration and Age Difference

Charge	Age of Victim	Age of Offender
Rape of a Child 1° Class A Violent Felony	Less than 12 years old	More than 24 months older than the victim
Rape of a Child 2° Class A Violent Felony	At least 12, less than 14	More than 36 months older than the victim
Rape of a Child 3° Class C Violent Felony	At least 14, less than 16	More than 48 months older than the victim

Charges: No Penetration/Yes Age Difference

Charge	Age of Victim	Age of Offender
Child Molestation 1° Class A Violent Felony	Less than 12 years old	More than 36 months older than the victim
Child Molestation 2° Class A Violent Felony	At least 12, less than 14	More than 36 months older than the victim
Child Molestation 3° Class C Violent Felony	At least 14, less than 16	More than 48 months older than the victim

Reoffense Risk

- Very challenging endeavor:
  - Why?
- Sexual recidivism, at a follow-up of about 6 years is approximately 13% (many studies show rates of less than 10%) [See Reitzel & Carbonnel, 2006].
- Non-sexual recidivism is significantly higher (e.g., 40%; See Worling & Langstrom, 2006).
- Research suggests that sex-plus offenders and youth that sexually abuse both child victims and peer/adult victims are at significantly higher risk for ongoing sexual and nonsexual criminal behavior (e.g., Butler & Seto, 2002; Parks & Bard, 2006).
- For youth receiving treatment = 7.37% sexual recidivism vs. receiving no treatment = 18.93% sexual recidivism (significant difference).

Reoffense Risk cont.

- Recent research demonstrates that some of the tools used to assess risk of juvenile sexual reoffense do *not* do a good job of predicting sexual recidivism (See Viljoen, Scalora, Cuadra, Bader, Chavez, Ullman, & Lawrence, 2008).

- It seems that one of the tools that has been studied, the Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR), does show some promise (Worling, 2004).

Reoffense Risk cont.

- Several emerging tools (e.g., JSOAP-II, ERASOR).
- Shelf-life issue.
- Non-sexual reoffense risk assessment.

Empirically Supported Risk Factors

- See Worling & Langstrom, 2006.
- Deviant Sexual Interest:
  - Youth who offend sexually AND who are sexually interested in prepubescent children and/or in sexual violence (e.g., Worling & Curwen, 2001).
    - Penile Plethysmography (PPG) is a robust predictor of sexual-assault recidivism for *adults* (e.g., Hanson & Bussiere, 1998) NOT for *youth* (e.g., Gretton, McBride, Hare, O'Shaughnessy, & Kumka, 2001).
    - Consider recent study about the utility of adolescent self-report as a way to assess deviant sexual interest (See Worling, 2006).

Empirically Supported Risk Factors cont.

- Prior sanctions for sexual offending.
- Sexual offending against more than one victim.
- Sexual offending against a stranger victim.
- Social isolation.
- Uncompleted offense-specific treatment.

Other Possible Risk Factors (limited empirical support)

- Problematic parent-adolescent relationships.
- Attitudes supportive of sexual offending.
- High-stress family environment.
- Impulsivity.
- Antisocial interpersonal orientation.
- Interpersonal aggression.
- Negative peer associations.
- Sexual preoccupation.
- Sexual offending against a male victim (only applicable to male offender).
- Sexual offending against a child.
- Threats, violence, or weapons in sexual offense.
- Environment supporting reoffending:
  - What would this look like?

Normal Sexual Behavior of Youth

- Major caveat – the large majority of research on sexuality at any age relies on self-report that may be replete with problems (e.g., recall errors, bias).
- Goldman and Goldman (1982):
  - Interviewed children ages 5-15 in four countries: Australia, Britain, North America, and Sweden.
  - Sexual learning and understanding lagged behind other aspects of cognitive development, except for Swedish children, who had received more sex education from an earlier age.
  - Larger families, especially those w/ opposite-sex siblings more advanced sexual thinking.
  - Boys somewhat more advanced than girls.
- Volbert (2000):
  - Interviewed 147 children ages 2-6.
  - Had knowledge of gender identity, genital differences, and sexual body parts.
  - Had little understanding of pregnancy, birth, and procreation, and almost no knowledge of adult sexual behavior (e.g., while 73.5% mentioned kissing and cuddling, only 8% of 6-year-olds and 3% of 5-year-olds gave a description of adult sexual behavior).
- Evidence suggests that children learn, first, about gender differences and body parts, somewhat later about procreation, and later still about sexual behavior.

Normal Sexual Behavior of Youth cont.

- Friedrich (2003b):
  - Child Sexual Behavior Inventory (36 items).
  - Parents complete the inventory, items are rated from "never" occurs to occurs "at least once a week."
  - Example of items: Touches sex parts in public; Masturbates with a toy or object; Touches another child's sex parts; Rubs body against people or furniture; Puts objects in vagina or rectum; Pretends that dolls or stuffed animals are having sex; Talks about sexual acts; Is very interested in the opposite sex.
  - Based on Friedrich's years of research, the following behaviors were endorsed by at least 20% of parents in each age group:

Normal Sexual Behavior of Youth cont.

2-5 boys: Stands too close to people (29.3%); Touches sex parts when in public places (26.5%); Touches or tries to touch their mother's or other women's breasts (42.4%); Touches sex parts at home (60.2%); Tries to look at people when they are nude or undressing (26.8%).

2-5 girls: Stands to close to people (25.8%); Touches or tries to touch their mother's or other women's breasts (43.7%); Touches sex parts at home (43.8%); Tries to look at people when they are nude or undressing (26.9%).

6-9 boys: Touches sex parts at home (39.8%); Tries to look at people when they are nude or undressing (20.2%).

6-9 girls: Touches sex parts at home (20.7%); Tries to look at people when they are nude or undressing (20.5%).

10-12 boys: Is very interested in the opposite sex (24.1%).

10-12 girls: Is very interested in the opposite sex (29.7%).

* Although children vary in the age at which the shift towards "concealed" sexuality occurs, in response to learning about sexual taboos, it appears to occur somewhere between the ages of 6 and 10.

Normal Sexual Behavior of Youth cont.

- Reynolds, Herbenick, & Bancroft (2003):
  - 154 female and 149 male 18-22 year-old college students.
  - Answered an extensive series of questions about sexual experiences in childhood.
  - 87% of males and 84% of females reported childhood sexual experiences with peers (CSEP).
- Original Kinsey Study (50 years prior):
  - 1,913 males and 1,770 females.
  - 68% of males and 42% of females reported CSEP.
- Suggests an increase in CSEP over the past 50 years as well as a much greater increase for females.
- CSEP were more common during elementary school years than pre-elementary.
- CSEP involving genital touching or more advanced sexual behaviors increased with age.
- Most frequently stated reason – curiosity.
- Physical and sexual pleasure as a reason was more common during junior high school, particularly for the boys.

Normal Sexual Behavior of Youth cont.

- Age at first masturbation:
  - Bancroft, Herbenick, & Reynolds (2003):
    - 98% of men and 83% of women indicated that they had masturbated prior to the study.
    - 38% of men and 40% of women reported first masturbation before puberty.
    - 80% of men had started to masturbate within 2 years before or after the onset of puberty.
    - For women, the age of onset was much more widely spread, and on average, started earlier than males.

Normal Sexual Behavior of Youth cont.

- What is innocent sexual behavior of children (less than 12 years old):
- Children are within about two years, and are touching each other or looking at each other.
- Children are giggling when touching or looking at each other.
- Behaviors is the idea of both persons… no threats or bribes used.
- If the behavior stops when one of the children asks for it to stop.
- The children have not been caught previously for sexual behavior.
  - Kahn (2002)

Problematic Sexual Behavior of Youth

- Sexual behavior of children (less than 12 years of age) that is "not innocent":
  - One of the children is more than about two years older than the other child.
  - Acts include penetration, intercourse, or oral sex.
  - One of the children coerces, threatens, bribes, or forces the other child.
  - One of the children is angry or serious during the activity.
  - The behavior does not stop when one of the children asks to stop.
  - One of the children has been confronted previously, and does it again.
    - Kahn (2002)

Problematic Sexual Behavior of Youth cont.

- Gray, Busconi, Houchens, & Pithers (1997):
  - Defined children with sexual behavior problems as 6- to 12-year-olds who engaged in sexual behaviors that were:
    - (1) Repetitive; (2) Unresponsive to adult intervention and supervision; (3) Equivalent to a criminal violation, if performed by an adult; (4) Pervasive, occurring across time and situations; or (5) A diverse array of sexual acts.
- Literature shows that during adolescence, sexual behavior, particularly in terms of early age at first sexual intercourse, number of sexual partners, and sexual risk taking, is associated with other types of problematic or “delinquent” behavior, such as drug and alcohol use (Bancroft, 2006).

Assessment

- There are at least five possibilities when an adolescent commits a sexual offense:
  - Those who continue and are never detected.
  - Those who continue despite detection/treatment.
  - Those who stop after being detected and treated.
  - Those who stop after being detected.
  - Those who stop on their own without ever being detected.
    - Worling, 2006

Assessment cont.

- Assessment of youth who have sexually abused:
- Washington is one of a few states that has a formal certification process for Sex Offender Treatment Providers:
- To become a Certified Sex Offender Treatment Provider:
  - Graduate degree
  - Pass of state exam
  - 2000 treatment hours (250 evaluation hours) under approved supervisor
  - DSHS Provider Search = https://fortress.wa.gov/doh/hpqa1/Application/Credential_Search/profile.asp
  - DSHS SOTP Directory.

Assessment cont.

- Guidelines for a thorough assessment:
- I. Evaluators should have: (1) a high level of training and expertise regarding the assessment of youth and their families; (2) a high level of training and expertise regarding the etiology, assessment, and management of sexual violence; and (3) familiarity with the existing research regarding juvenile sexual assault recidivism.
- II. Evaluators should assess multiple domains of the youth's functioning, including sexual (e.g., sexual arousal, sexual attitudes, sexual history, sexual preoccupation); intrapersonal (e.g., affective expression, impulsivity); interpersonal (e.g., social involvement, aggression); familial (e.g., parent-child relationships, family distress); and biological (e.g., neurological, physical health).
- III. Evaluators should use multiple methods of data collection to form opinions. Methods could include clinical interviews, psychological tests, behavioral observation, medical examinations, and reviews of previous case records and reports. At a minimum, evaluators should collect information directly from the offending youth AND from official records regarding the youth's sexual offense(s).

Assessment cont.

- Guidelines for a thorough assessment cont.:
- IV. Evaluators should collect information from multiple sources such as the youth, the victim(s), the police, family, friends, and other mental health professionals who are familiar with the offending youth and his/her family. At a minimum, evaluators should collect information from the adolescent, adults responsible for the adolescent's care, and official records regarding the adolescent's sexual offense(s).
- V. Evaluators should collect information regarding both static (historic and unchangeable) and dynamic (variable and potentially changeable) risk factors.
- VI. Evaluators should always be cognizant of the validity of the information that they are using in forming risk predictions and should state any reservations of qualifications in their reports.
- VII. Evaluators should recognize that risk assessments will become obsolete after the passage of time and/or following a change in ANY of the risk factors that were assessed.
  - Worling, 2006.

Assessment cont.

- Evaluations also typically include a plan for managing risk and providing treatment as well as factors pertaining to supervision.
- General categories of evaluations:
  - **Reason For Referral**
  - **Evaluation Procedures**
  - **Tests Administered**
  - **Notification of Rights**
  - **Relevant Personal History (e.g., developmental history, family history, social history, academic history)**
  - **Official Version of Sexual Abuse Allegations**
  - **Youth's Version of Sexual Abuse Allegations**
  - **Sexual History**
  - **Psychological Test Results**
  - **Mental Status/Current Functioning**
  - **DSM-IV Diagnostic Impressions**
  - **Assessment of Risk (Sexual and Nonsexual)**
  - **Amenability for Treatment**
  - **Recommendations (i.e., Treatment, Supervision)**

Assessment cont.

- Two primary questions of evaluations:
  - (1) Risk of sexual reoffense:
    - A LOT of focus on this construct.
  - (2) Amenability for treatment:
    - Very little focus on this construct??
      - RSTI

Assessment cont.

- 15 RSTI Treatment Amenability Items:
  - Degree of psychopathology (e.g., severe conduct disorder)
  - Treatment of psychopathology (e.g., known/relatively successful treatment procedures)
  - Anxiety about the circumstance
  - Motivated to engage in treatment (e.g., perceive treatment would be worthwhile)
  - Aware of difficulties/problems

Assessment cont. - RSTI

- Takes responsibility for actions
- Feels guilt/remorse
- Expects change
- Open to change
- Insight into cause of problems
- Positive involvement by parents
- Limited police/court/probation involvement
- Considers and generally cares about others
- Has protective factors
- Has positive attachments

Assessment cont.

- Typical Juvenile Sexual Behavior Evaluation and Risk Assessment:
  - 1 to 3 interview sessions.
  - Collateral interviews (parents, teachers, therapists).
  - Records review (legal, academic, mental health).
  - Psychological testing:
    - Behavior, Personality, Cognitive/learning, Attitudes/Beliefs, Sexual Interest, Risk
  - Psychophysiological testing.

Treatment

- Basic points:
  - There is a lot that we don't know about treatment of youth who have committed sexual offenses:
    - What specific treatments are better than others?
    - Dosing and length?
    - Format of treatment (e.g., individual vs. group)?
  - There are some things that we know more about:
    - Treatment is helpful at reducing the risk of future sexual and nonsexual criminal behavior (Reitzel & Carbonell, 2006), especially when treatment is successfully completed (Gretton et al., 2005).
    - Some evidence suggests that specialized SO treatment is more effective than standard treatment for youth who are incarcerated for sexual offenses (e.g., Waite et al., 2005).
    - Based on consensus-based research – most treatment providers rely on cognitive-behavioral, relapse-prevention, and psychosocial educational treatment models (McGrath, Cumming, & Burchard, 2003).

Treatment cont.

- Treatment is helpful at reducing future sexual and nonsexual offending (Rietzel & Carbonell, 2006):
  - Meta-analysis of 9 studies comparing effectiveness of treatment as measured by recidivism.
  - For JSOs receiving treatment = 7.37% sexual recidivism vs. receiving no treatment = 18.93% sexual recidivism (significant difference).
  - Less clear about what type of treatment is most helpful.
    - In the adult literature, CBT is most effective.
    - However, MST was not classified as CBT in this meta-analysis & both treatment/comparison groups in the Waite et al (2005) study relied upon CBT.
    - In addition, prior meta-analysis (Walker et al., 2004) did demonstrate that CBT was most effective type of treatment.

Treatment cont.

- Consensus-based findings:
- Safer Society Survey 2002 (McGrath et al., 2003):
  - Top three program theories selected by each male adolescent program:
    - Cognitive-behavioral
    - Relapse prevention
    - Psychosocial education

Treatment cont.

- Treatment Targets:
  - Offense responsibility
  - Cognitive restructuring
  - Intimacy skills
  - Social skills
  - Victim empathy
  - Relapse prevention
  - Arousal control
- SSRIs are the pharmacological treatment of choice for treatment programs of JSOs.

Treatment cont.

- Due to research findings that the following dynamic factors are believed to be associated with sexual recidivism, they are commonly included in specialized treatment of JSOs:
  - Deviant sexual interests.
  - Problematic parent-child relationships.
  - Social isolation, poor social skills, low social self-esteem.
  - Antisocial values and behaviors, including emotional callousness and an absence of empathy for others.
  - Pro-offending attitudes or cognitive distortions.
  - Impulsivity.
  - Treatment non-completion.
    - See Hunter et al., 2003; Longo & Prescott, 2006; Worling & Langsrom, 2006.

Treatment cont.

- In absence of manualized, empirically-supported treatment programs/methods, there are a few findings from research worth reviewing:
  - Worling & Curwen (2000) compared a group of JSOs receiving specialized treatment (N = 58) to a group of JSOs that received either only a psychosexual evaluation and no treatment or an evaluation with non-specific SO treatment (N = 90). After a mean follow-up timeframe of 6 years.
  - When compared to the control group, they found that JSOs receiving specialized treatment had a lower rate of future sexual offenses (5% vs. 18%); violent nonsexual offenses (19% vs. 32%); and nonviolent offenses (21% to 50%).
    - The specialized treatment involved weekly individual, group, and family therapy over the course of at least 12 months.
    - The specialized SO program was generally focused on cognitive-behavioral and relapse-prevention treatment of denial and accountability, deviant sexual arousal, sexual attitudes, victim empathy, as well as more general issues such as social skills, self-esteem, anger expression, trust, and intimacy.
      - Though, the program was individually tailored to the youth.

Treatment cont.

- Multisystemic Therapy (MST):
  - Two randomized clinical trials:
    - Borduin, Henggeler, Blaske, & Stein, 1990 : one group received home-based MST by doctoral level therapists, one group received outpatient therapy by mental health professionals (N = 16).
      - Sexual recidivism at 3 year follow-up = 12.5% vs. 75%.
    - Borduin & Schaeffer, 2001; Borduin, Schaeffer, & Heiblum, 2007: one group received other group received CBT group and individual therapy administered in juvenile court setting (N = 48).
      - Sexual recidivism at 8.9 year follow-up = 12.5% vs. 47%
      - Nonsexual recidivism at 8.9 year follow-up = 29.2% vs. 62.5%.

Treatment cont.

- Brief critique of MST research to date:
  - Comparison groups may not be adequate to what commonly occurs with this population (e.g., meetings with probation officers, treatment by outpatient mental health providers).
  - Population may not be comparable to most juveniles who commit sexual offenses (e.g., 75% recidivism) – may be a very high risk population.
  - Treatment was developed for youth who exhibit severe antisocial behavior. May be most appropriate for sex-plus, versatile, youth who exhibit severe antisocial patterns.
  - Important to remember there is no such thing as a “one-size” fits all approach (e.g., how to address sexual deviancy?).

Common Treatment Targets

- **1. Inappropriate Sexual Behavior (9 items):** The extent to which the adolescent displays inappropriate sexuality, shows deviant sexual interests, and is preoccupied with sexual matters.
- **2. Healthy Sexuality (10 items):** The extent to which the adolescent demonstrates an understanding and expression of healthy sexual behavior.
- **3. Social Competency (8 items):** The extent to which the adolescent shows appropriate social skills and has healthy social connections.
- **4. Cognitions Support of Sexual Abuse (6 items):** The extent to which the adolescent uses cognitions supportive of sexual abuse.
- **5. Attitudes Supportive of Sexual Abuse (6 items):** The extent to which the adolescent endorses attitudes supportive of sexual abuse.
- **6. Victim Awareness (4 items):** The extent to which the adolescent understands that he/she harmed the Victim(s) of the sexual abuse.
- **7. Affective/Behavioral Regulation (8 items):** The extent to which the adolescent is able to manage nonsexual and sexual impulses and learns from consequences of behavior.
- **8. Risk Prevention Awareness (7 items):** The extent to which the adolescent knows how to prevent additional sexual offenses.
- **9. Positive Family Caregiver Dynamics (6 items):** The extent to which the family caregivers appreciate factors related to the sexual abuse, practice appropriate parenting strategies, as well as the quality of interactions between the adolescent and family caregivers.
  - Taken from the Treatment Progress Inventory for Adolescents who Sexually Abuse (TPI-ASA) [Oneal, Burns, Kahn, Rich, & Worling, 2007].

Ways to Help Supervise and Support Youth with SBP

- Supervision:
  - Basic Guidelines:
    - Many of the same factors that are relevant for good general supervision.
    - Eliminate specific risks or temptations [What would that look like?]:
      - (e.g., unsupervised contact with younger children; access to pornography).
    - Encourage physical activity that competes with sexual arousal.
    - Encourage peer-age, healthy, social interactions.
    - Provide appropriate supervision that allows practice of treatment skills.
    - Become involved in the youth's treatment process (e.g., Parents Group; Research supports parental involvement! – Worling & Langstrom, 2006).
    - Be aware of legal age range.
    - Become involved with peer-group, parents of peer-group.
    - Become knowledgeable with technology (e.g., computer, ipod, texting, My Space, internet use, handheld game units, Wii, etc.).
    - Have a set and approved Supervision Plan.

Ways to Help Supervise and Support Youth with SBP cont.

- Supervision Plan Items:
  - Visits at friend’s homes; overnights (consider potential victims)
  - Neighborhood activities
  - Parks/schools
  - Beaches/pools (locker rooms)
  - Movies
  - At home alone
  - Jobs
  - Dating
  - Parties

Ways to Help Supervise and Support Youth with SBP cont.

- Technology Considerations (Google anything that you have a question about):
  - Movies: Avoid violent and adult content movies. Monitor and adhere to rating system.
  - Video Games: Avoid violent and adult content games. Monitor and adhere to rating system.
  - Music: Limit parental advisory music. Monitor and get to know music (Google song for lyrics).
  - Television: Avoid having TV in bedrooms, limit amount of TV watching.
  - Computer: Locate computer in main living area, with good supervision, limit amount of computer use.
    - Consider adding password
    - Consider software that prevents access to adult sites
    - Learn how to check history and do so discretely and regularly
    - Avoid on-line computer gaming, chatting
    - My Space, Face Book??

Ways to Help Supervise and Support Youth with SBP cont.

- Develop Healthy Boundaries in the Home:
- Avoid excessive physical contact between siblings (what would that look like?)
- No pornography in the home
- Keep play within legal age ranges
- Encourage physical activities such as sports
- Everyone wears clothes in the home
- No going into other's bedrooms
- Consider bedroom door alarms
  - See *Pathways Guide for Parents* (Kahn, 2002).

Ways to Help Supervise and Support Youth with SBP cont.

- When youth with sexual behavior problems enters home:
  - First, may be best to think about *General Precautions*… kids may have sexual behavior problems and you don't know about them!
  - Provide direct, line of sight supervision (especially until get to know youth better).
  - Get all available reports.
  - Communicate regularly with treatment providers and school teachers.
  - Carefully segregate rooms based on age and related factors.
  - Remember that sexual offending is contextual!

Ways to Help Supervise and Support Youth with SBP cont.

- Some Warning Signs to Consider:
  - Youth is spending significant time alone.
  - Youth seeks out younger children for play.
  - Youth is caught masturbating (particularly if this has happened several times).
  - There is evidence of excessive or public masturbation.
  - Youth has sexually explicit material in possession.
  - Other children are complaining that youth is talking about sex, or asking to do sexual things with them.
  - Child has been sneaking into other bedrooms, or clothing is missing in house.
  - Child is repeatedly initiating wrestling or other physical contact.

Contact Information

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