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Profiles of Children and Youth Displaying Inappropriate Sexual Behaviours: Relevance for Assessment for Sexual Offending Patterns

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A thesis submitted in partial fulfillment of the requirements for the Master of Education degree in Psychology

Profiles of Children and Youth Displaying Inappropriate Sexual Behaviours: Relevance for Assessment for Sexual Offending Patterns

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Abstract

The purpose of this study was to evaluate a specialized assessment program with a sample of children/youth (n = 80) who were seeking intervention for inappropriate sexual behaviour (ISB) at a tertiary mental health facility in London, Ontario. The primary goal was to identify predictive factors in participants with offending behaviour—both sexual and non-sexual—in order to prioritize treatment needs and to address strategies for reducing the risk of sexual offending against others. As participant ages increased by 1 year, their odds of sexually offending someone were found to increase by approximately 27%. Also, males were found six times more likely to sexually offend and 15 times more likely to offend both sexually and non-sexually than females. However, findings suggest that trauma may play a mediator role to sexually offending patterns as those who experienced greater levels of abuse were less likely to sexually offend against others. Future assessments with clients exhibiting ISB should consider the aggregated burden of risk presented with an older male, displaying high externalizing scores, with a history of fewer traumatic experiences in regards to future victimization. Treatment for these particular cases may require more intensive and/or holistic interventions to ensure that recidivism is reduced and appropriate resources are available to support these youth as they continue to develop. Future directions should be considered to advance understanding in this area.

Keywords: Children; Youth; Inappropriate Sexual Behaviour; Sexual Offending; Assessment

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The purpose of this study was to evaluate a specialized assessment program with a sample of children/youth who were seeking intervention for age-inappropriate sexual behaviour at a tertiary mental health facility in London, Ontario. According to the Canadian Incidence Study of Reported Child Abuse and Neglect (2008), inappropriate sexual behaviour is defined as "age-inappropriate play with toys, self or others; exhibiting explicit sexual acts; age-inappropriate sexually explicit drawings and/or descriptions; sophisticated or unusual sexual knowledge; prostitution or seductive behaviour" (Trocmé et al., 2010, p. 38).

The primary goals of this study were to identify those children and youth with concerning behaviour as it deviates from normative development in sexual behaviour and to understand the factors that contribute to its early evolvement. In obtaining these objectives, strategies to reduce the risk of sexual victimization can be addressed. Further, identifying areas of strength and protective factors in this sample of children/youth could enhance age-appropriate functioning and reduce the risk of continued inappropriate sexual behaviour.

Literature Review

Inappropriate Sexual Behaviour (ISB) and exploitation of children/youth holds significant emotional, personal, social, and financial costs (Moore, Talley, Franey, Crumpton & Geffner, 2005). Individually, victims of sexual perpetration exhibit a range of symptoms such as guilt, self-blame, social withdrawal, depression, family problems, low self-esteem, somatic complaints, irrational fears, and difficulties with sexuality (Cahill, Llewelyn & Pearson, 1991; Trocmé, et al., 2010). Further, victims report experiences with long-term consequences such as anxiety, depression, suicidal ideation, difficulties in relationships, self-harm, prostitution, eating

disorders, sexual dysfunction, and even psychopathy (Trocmé, et al., 2010; Daversa & Knight, 2007; Palmer, Chaloner & Oppenheimer, 1992).

Socially, ISB has been linked to concerns in adolescence including conduct disorder, risky sexual behaviour, risk of contracting sexually transmitted infections, and unplanned pregnancy (Verweij, Zeitsch, Bailey & Martin, 2009). Additionally, children/youth are at higher risk to victimize other children/youth (Dirks, Treat & Weersing, 2010) since they are in close proximity on a consistent basis. For example, sex offenses committed between juveniles are more likely to occur at schools or in groups compared to offenses that occur between adults and juveniles (Finkelhor, Ormrod, & Chaffin, 2009).

Burton (2003) investigated how sexually abusive behaviour in male adolescents was related to their personal victimization histories. Findings suggest that sexually abused youth were more likely to victimize others in a manner that was similar to their own experience. For example, their victimizing behaviour towards others often paralleled the method and approach that their abusers adopted with them. This suggests that children/youth are more often at risk of exposure than initially realized. Risk is not only present through avenues reflecting adult-child victimization; it is also prevalent through less overt avenues associated with peer on peer victimization. As children/youth engage more frequently through technology (i.e., the various options available through internet and mobile messaging), there is a risk for victimization occurring more frequently and with "seeming impunity" (Jones & Finkelhor, 2003). In addition, given that many of these avenues are not as closely monitored by a child/youth's caretakers, under-reported acts of sexual abuse may actually suppress an awareness of the extent of victimization. The implication to such under-monitored and under-reported victimization between youth relates to the effect it has on perpetuating the sexual offending cycle.

Financially, the costs of victimization are exponential. Overall, child abuse costs exceed 15 billion dollars in Canada per year (Little Warriors, 2010). Of this annual total, personal, social services, and health costs aggregate to 2.3 billion, 1.1 billion, and 2.2 million dollars respectively. While these numbers include all forms of child abuse, it is important to consider that child sexual abuse is not a mutually exclusive experience of other forms of abuse; the greatest degree of overlapping risk factors exists between children who experience alternate forms of abuse beyond sexual victimization (Daversa & Knight, 2007; O'Brien, 2010).

Prevalence of ISB in Children/Youth

Statistics on children/youth who exhibit ISB are becoming increasingly evident with respect to their role within the cycle of abuse; in this instance, sexual abuse. Children/youth may be responsible for up to 90% of sexual assaults of other children/youth (Taylor, 2009) since juvenile offenders are more likely than adult sex offenders to victimize young children (i.e., younger than 12 years; Finkelhor, Ormrod, & Chaffin, 2009). In 2009, the National Center for Juvenile Justice reported that over half (57.1%) of the US sexual offenses committed by children/youth under the age of 12 years involved victims 6 years and younger (Finkelhor, Ormrod, & Chaffin, 2009). In Canada, children between the ages of 4-7 years have consistently represented the highest number of child maltreatment investigations since 1998 (Trocmé, et al., 2010). In 2005, it was estimated that children/youth were five times more likely to experience sexual assault than adults (Canadian Centre for Justice Statistics, 2007).

Recent crime statistics have indicated that up to 33% of all sexual offences in Canada are committed by persons under 21 years of age (Little Warriors, 2010) and that 61% of all sexual abuse incidents reported are against children—despite comprising only 21% of the population (Canadian Centre for Justice Statistics, 2003). Youth are also responsible for a significant

portion of violent sexual acts (Jones & Finkelhor, 2003). These persons often target children much younger than themselves; however, it is important to differentiate between those children/youth that display self-focused sexual behaviour that creates problems for themselves, but does not harm others, and those children/youth who engage in sexual behaviours that are harmful towards others. To help differentiate these populations, prior research has been devoted to identifying various traits or characteristics associated with each.

Traits of Children/Youth Exhibiting ISB

O'Brien (2010) provides an overview of recurrent traits with children/youth who exhibit ISB. Such traits include adverse parental/caregiver circumstances, poor parental/caregiver mental health, unstable living arrangements, imminent court processes, grief and loss, recent victimization, and unstable case planning. Specifically, strong correlations were found between children with ISB and: (1) social exclusion, including not being able to participate in social and economic activities (Saunders & Wong, 2009) due to physical, geographical, or cultural inabilities (Saunders, 2008); (2) family dysfunction; (3) poverty; and (4) geographic disadvantage (i.e., increased difficulty in accessing services due to family's remote living arrangements). While O'Brien synthesizes the descriptive literature in this area, it is clear that evidence-based literature on treatment outcomes for this population is not specific enough to address individual needs.

Evidence suggests the roles of attachment, intimacy deficits, and loneliness in youth involved in sexual offending are important (Marshall, 2010) and these traits are sustained through to adulthood (Bornstein, Hahn & Haynes, 2010). Marshall (2010) reported that sexual abuse by a family member is predictive of poor child-parent attachment. Loneliness and isolation is heightened by a lack of family involvement, social exclusion, and/or poverty.

Further, feelings of prolonged emotional loneliness frequently lead to increased aggression (Marshall, 2010; Jones, 2002). With respect to identifying common traits with children/youth exhibiting ISB, questions remain as to whether intimacy deficits are accurately identifiable within child/youth populations where development of abilities to formulate and/or express such deficits may not yet be present.

Factors that predispose adolescents to sexually victimize others are identified in reference to children/youth exhibiting ISB (Moore, Talley, Franey, Crumpton & Geffner, 2005). However, little is known regarding what traits distinguish children/youth who victimize others and those who do not. Moore et al. (2005) address the high costs associated with sexual offending (i.e., costs for victims, families, offenders, and the general society); less awareness, however, is given to the costs associated with ISB of those who do not offend against others. For example, for those who offend against others, the need for intervention is more overt than for those who do not offend. Nonetheless, the need for psychological intervention remains the same for each regardless of their externalized behaviour. Whether an exhibitor of ISB offends against others or not, their psychological disposition can still elicit indirect costs to their person, family, and society as its consequences begin to affect various aspects of their life (i.e., school, work, relationships, and so forth).

Formulating Typologies of Children/Youth Exhibiting ISB

Two empirical studies represent initial attempts at developing a typology or 'cluster' of traits that may contribute to developing a typology of children/youth with ISB (i.e., Bonner, Walker & Berliner, 1999; Pithers, Gray, Busconi & Houchesn, 1998). Log linear analysis and hierarchical cluster analysis were used, respectively, to identify sub-groups of participants based

on presenting traits and demographics. Once these typologies were developed, clinical trials were conducted to compare two randomly assigned treatments.

Bonner, Walker, and Berliner (1999) used scores on the Child Sexual Behaviours Inventory (CSBI) to identify three sub-groups according to behaviour severity: (1) sexually inappropriate, (2) sexually intrusive, and (3) sexually aggressive. Each participant was randomly assigned to either Cognitive Behavioural Therapy (CBT) or Dynamic Play Therapy (DPT). While participants from both treatment groups made significant improvements to ISB relative to their behaviour at the beginning of the study, no significant differences were found between treatments. Researchers did, however, find that the aggressive sub-group was primarily comprised of participants who were older, male, and scored higher on general aggression relative to the other sub-groups.

Pithers, Gray, Busconi, and Houchesn (1998) drew on characteristics from family and social contexts, abuse histories, and demographics to identify their five profiles. These included: (1) sexually aggressive, (2) rule breakers, (3) highly traumatized, (4) abuse reactive, and (5) non-symptomatic. Similar to Bonner et al. (1999), participants were randomly assigned to either CBT or Expressive Play Therapy (EPT). Results indicated that half of those with the aggressive profile decreased their sexual behaviour problems, while the other half actually increased their problems. However, rule breakers tended to do equally well with both treatments, which was attributed to gender differences (i.e., this group had a disproportionate amount of females). It remains unknown which traits define improvement in the aggressive profile versus those that define deterioration and why these outcomes are not the same.

Hall, Mathews, and Pearce (2002), in a retrospective study, examined the differences between three stable typologies of children presenting with ISB between the ages of 4-7 years.

These included: a) Interpersonal-Unplanned; b) Interpersonal-Planned (non-coercive); and c) Interpersonal-Planned (coercive). The most severe category reported was Interpersonal-Planned (coercive) as these children were most resistant to counselling and limit setting. Children from this cluster differed by their severity of behaviour, degree of planning, amount of sexual preoccupation, amount of coercion, and they were reported to have most likely experienced pain and arousal during sexual abuse. Further, children from the planned (coercive) cluster were more likely to come from families where parental supervision was poor, attitudes within the home supported pairing sex with violence, and parents minimized the role of counselling or resisted it due to denial.

Literature regarding typologies is important in gaining an understanding about which children/youth may be at risk of ISB—as either a victim or a victimizer. However, it is not enough to acknowledge the differences or similarities within this population. Oneal, Burns, Kahn, Rich, and Worling (2008) published their initial psychometric efforts for adolescents who sexually offend. A more detailed understanding of children/youth's needs prior to treatment would enable service providers in delivering more effective treatment. Oneal et al. developed an inventory targeting treatment planning and progress. Nine dimensions were isolated as appropriate behavioural measures and included: a) inappropriate sexual behaviour; b) healthy sexuality; c) social competency; d) cognitions supportive of sexual abuse; e) attitudes supportive of sexual abuse; f) victim awareness; g) affective/behavioural regulation; h) risk prevention awareness; and i) positive family caregiver dynamics. From these dimensions, areas indicating the most urgency could be treated in priority sequence.

These findings are important since they indicate the necessity for further investigation on unique treatment approaches and the need for a greater understanding regarding how they affect

clients differentially according to personal contexts. While characteristics of children/youth that victimize others tend to mirror the *modus operandi* of their perpetrators as mentioned above (Burton, 2003), evidence supports the success of specialized treatment for adolescent sexual offenders in decreasing both sexual and non-sexual recidivism rates (Worling, Litteljohn & Bookalam, 2009). Certain treatments have been shown to be effective in reducing ISB in children/youth; however, it is not clear which treatment factors are most robust in sustaining success beyond the termination of treatment.

Threats to Treatment Success

Incorporating specialized treatment is integral to efforts in reducing future ISB. Research has helped to identify common traits within children/youth that exhibit ISB, as well as associated risks to long-term treatment success. While comparisons have been drawn between specific treatment approaches (e.g., CBT, DPT, EPT), findings have been somewhat inconclusive in isolating best practice treatment outcomes. For example, a limited number of studies report on empirical typologies that may help to identify which sub-group of children/youth may optimally respond to a specific treatment option (Chaffin, Letourneau & Silovsky, 2002). One explanation for these research limitations could be reflective of the heterogeneous nature of the ISB child/youth population (Chaffin et al, 2002; O'Brien, 2010). Moreover, with such different histories, any given combination of traits within these children/youth may elicit a need for more individualized treatment plans (Rasmussen, 2005).

Complexity of histories. Given that children/youth who exhibit ISB present with their own predisposition, genetic makeup, and history, accurate predictions regarding how successful treatment will be for all children/youth involved is of critical importance. This is the current focus in building a strategic approach that encompasses contextual information that is unique to

each child/youth. The challenge remains in addressing which combination of client traits can inform practitioners in choosing their therapeutic approach. More specifically, while some clients may respond best to CBT, others might respond best to another approach.

Veneziano and Veneziano (2002) support the notion that treatment success is dependent on individualized plans of care that accommodate the history of each client. Children/youth displaying ISB have heterogeneous characteristics and treatment needs (Rasmussen, 2005; Hunter, Hazelwood, & Slesinger, 2000). Therefore, a thorough understanding of how clients' current levels of functioning are shaped by their histories can facilitate more effective treatment. For example, ISB in some clients may present primarily as internalized behaviour such as depression, anxiety, and social withdrawal (Jones, 2002; Varia, Abidin & Dass, 1996). Since CBT has been effective in treating symptoms of this nature, incorporating this approach into treatment with these clients is often recommended. However, ISB in other clients may present with more externalized characteristics such as aggression, violence, or sexual perpetration (Jones, 2002). In trying to better understand triggers for externalized behaviour, play therapy might be effective in exploring different social situations (Nims, 2011). It may also be an effective way to help model appropriate behaviour with clients who struggle with this.

Home environment. A prominent contributing factor to history is the family dynamics present within the home environment (Nims, 2011). There is a risk of relapse if, for example, significant adjustment has been made on the child/youth's part without similar adjustments made within the home environment (Hair, 2005). Tailoring an effective therapeutic approach to individual client needs is integral to long-term treatment success, but if those needs are not supported at home, post-treatment gains subside.

Access to services. As with the risks outlined in home environments, having access to services that are conducive to growth is essential in maintaining adaptive treatment trajectories (Casey et al., 2010). Without consistent access to service, it may not be possible to gauge whether it is the treatment approach adopted that impedes long-term success, the dynamics within the home environment, or whether necessary follow-up services are not being utilized. Lyons, Uziel-Miller, Reyes, and Sokol (2000) address the importance in re-establishing community participation for clients post-treatment. They suggest that restoring ties to the community can help clients to assimilate back to their home environment after the support of their service providers becomes limited. Lastly, Casey et al. (2010) discuss the critical role that transition services can have on facilitating treatment success post-discharge. While clients present with different strengths and skills at discharge, some areas of functioning may require further development in order to ensure that these deficits do not influence post-treatment outcomes (Casey et al., 2010). Future directions in longitudinal research require solutions to ameliorating barriers to accessibility.

Gaps in the Literature

While researchers of ISB have contributed significantly to the literature regarding the identification of typologies and risk factors relevant to treatment success, modest contributions have been made regarding the differences between children/youth exhibiting ISB who victimize others, and children/youth exhibiting ISB who do not. In a recent study on sexually abused children, Buchta, (2010) examined within-group differences between sexual offenders. Specifically, children who had victimized others had significant rates of ISB compared to subclinical rates for those with no reported prior victimization. Those children/youth who were identified as victimizers also reported higher expectations for anger, felt less likely to experience

positive events, and were generally less efficacious than children/youth that did not victimize others. While these findings are important in assessing children/youth with multiple risk factors, concern regarding the use of this information in tailoring treatment plans remains. Additionally, given that not all treatment approaches are effective with all victims, further assessment is required to accommodate individual risk factors within treatment so that aggregate costs and barriers to treatment success can be ameliorated.

Initial stages of research that involve treatment comparisons made thus far, are integral to therapeutic advancement with ISB in children/youth. However, with no clear indication as to which treatment is most effective with which typology, the focus of future research will be to improve our understanding regarding which interventions are most effective with which types of ISB exhibitors. In other words, highlighting personal needs in a child/youth profile that can enable service providers to individualize treatment plans will help clinicians to deliver best-practice solutions and encourage long-term benefits to all involved. Prioritizing client needs and addressing overlapping risk factors may help to ameliorate some of the challenges in approaching ISB populations that are heterogeneous in nature. For example, some clients may present with a combination of symptoms that alter their response to standard treatment protocols. If a client displays behaviour consistently treated with one evidence-based approach, how is their trajectory affected if they also display behaviour inconsistent with that same approach? More specifically, if a client presents with both externalized behaviour (i.e., sexually victimizing others, aggression, or misconduct) and internalized behaviour (i.e., anxiety, withdrawal, or depression), which treatment protocol should be chosen? Are there situations where certain risk factors or characteristics can be used to inform clinicians on how to best meet such holistic therapeutic needs? If so, how can treatment priorities be addressed with respect to choosing the

best approach and which factors will influence how this varies from client to client? A greater understanding of how different typologies respond to various treatment modalities may facilitate more effective long-term success.

Another facet to consider is that research methodology and successful treatment options may not remain effectively static over time; advancing in response to the dynamics of an ever-changing society (i.e., changes in theoretical and technological knowledge). For example, Trocmé, Fallon, MacLaurin, and Neves (2005) report that, between 1993 and 1998, substantiated sexual abuse rates decreased by 50% in Canada. Additionally, Jones and Finkelhor (2003) address the reasons underlying a 40% decline in substantiated sexual abuse cases across the US by child protective service agencies between 1992 and 2000. While it is hopeful that these declines reflect the efforts of prevention, treatment, and judicial activity, other possible explanations include increased conservatism with regards to abuse allegations; exclusion of cases not involving caretakers; changes in data collection methods or definitions; and less reporting due to potential backlash (Jones & Finkelhor, 2003; Trocmé, et al., 2005). Backlash might include traumatic outcomes such as accusations of false allegation, blame, breakdowns in support, and exacerbated symptoms or victimization (Paine & Hansen, 2002, Summit, 1983). These changes in sexual abuse research across time further support a need for constant assessment and investigation.

Importance of Further Assessment

Understanding ISB in children/youth can have a positive impact on the behaviour of many clients and can help to avoid future needs for more intrusive and costly treatments (Daversa & Knight, 2007; Rasmussen, 2005). Research indicates that understanding antecedents and core traits involved in ISB can help to identify paths to victimization and also distinguish

between children/youth that may victimize other children/youth (Daversa & Knight, 2007). For example, Daversa and Knight (2007) suggest that models of ISB in children/youth that are reflective of adult-child molestation patterns can be useful in understanding motivation factors, tendencies, and capabilities of likely victimizers.

Further assessment is necessary to support knowledge of all types of children/youth exhibiting ISB. In accordance with their Sexual Behaviour Team approach at the Child and Parent Resources Institute in London, Ontario, Canada, Stewart and Marshman's (2010) suggest that primary goals for treating ISB should be to: (1) identify ISB that deviates from normalized developing sexual behaviour; (2) gain a better understanding of ISB and the factors that influence its occurrence; (3) create safety plans to prevent ISB from re-occurring; (4) explore ways to better manage and improve ISB; (5) outline strategies and contextual influences that help to reduce the risk of ISB (i.e., "implementing sexual behaviour rules and encouraging privacy and appropriate boundaries in the home"); (6) outline strengths and protective factors in clients and their families that promote appropriate client functioning and reduced ISB; (7) educate clients and families about healthy sexuality to encourage a normalized developmental path in their clients' sexual development; and (8) identify offense specific treatment needs that can be tailored to clients' individual strengths and risk factors.

Some predictable patterns have been identified in victims of ISB such as the victim-perpetrator theory of adolescent sexual offending (Burton, 2003). Children/youth that victimize have been known to report less experience with parental monitoring, lower rates of openly displayed affection, and more verbal abuse by their parents compared to children/youth exhibiting ISB who do not victimize (Lightfoot & Evans, 2000; Daversa & Knight, 2007; Haapasalo & Kankkonen, 1997). Perhaps this is an example where a more collaborative

treatment approach between child and parent could be effective rather than the aforementioned play- or cognitive-oriented therapies used solely with the child.

Daversa and Knight (2007) indicated the roles of emotional and physical abuse experienced by a child/youth that victimize others. Burton and Hedgepeth (2002) further suggest that the severity of sexual offenses committed by children/youth was related to rates of physical abuse; higher rates of physical abuse coincided with offenses involving penetration compared to less severe offenses as fondling or noncontact sexual behaviours. In order to provide effective intervention for children/youth exhibiting ISB, further assessment is required to support our previous findings and to advance our understanding of relevant treatment options.

The Current Study

The purpose of the current study was to profile traits within a child/youth sample with a recent history (i.e., within 6 months prior) of ISB in order to explore effective treatment options tailored to participants' individual needs. This study was secondary to a program evaluation conducted at the Child and Parent Resource Institute in London, Ontario.

Hypotheses

To facilitate the proposed descriptive analyses, predictions were made in accordance with the previous literature that sexual offending behaviour would accompany three main traits. First, a lack of family involvement such as with caregiver supervision or attachment was expected to be more prevalent in those who sexually offend. Second, adverse living environments such as family dysfunction or poverty were thought to increase the risk of sexual offending. Third, personal experience with sexual victimization (i.e., being sexually abused) was considered a prominent predictor of sexual abusive behaviour towards others.

With respect to offending patterns, it was hypothesized that children/youth who offend both sexually and non-sexually would report more experience with alternative forms of abuse (i.e., emotional and/or physical) and display greater levels of conduct related problems such as externalizing behaviours than those who offend sexually alone.

Method

For the purposes of the current project, a profile of presenting ISB traits were compiled from clients referred to the Sexual Behaviour Team (SBT) services at the Child and Parent Resource Institute. This was a descriptive field study where differences were drawn between clients who exhibit ISB with and without prior history of personal victimization; as well, differences between clients who exhibit ISB who have and have not committed offences—sexual and/or non-sexual.

Participants

The dataset used for this study contained demographic and clinical information from 80 children/youth between the ages of 6 and 18 years (M = 13.12, SD = 2.70). The SBT clients are male (83.8%) and female (16.3%) with varying levels of development and functioning; for example, children/youth referred to the SBT were also seeking services for either mental health issues (e.g., conduct, emotional and attachment disorders, mood disorders, tourette syndrome), or developmental delay issues (see Table 1 for an overview of sample descriptives). Nearly half (42%) of participants were reported to have experienced sexual abuse upon referral to the SBT and roughly one third (34%) had been exposed to both emotional and physical abuse. Almost all participants (93%) exhibited offending behaviour of some form and this was exclusively categorized as sexual offending (18%), non-sexual offending (31%), or both sexual and non-sexual offending (45%).

The Child and Parent Resource Institute. The Child and Parent Resource Institute (CPRI) is a tertiary mental health facility in London, Ontario, Canada that specializes in providing residential treatment services to families that have been clinically referred for inpatient service. As a regional provider of highly specialized treatment services, CPRI is a research based organization, committed to developing effective and efficient treatment. In 2003, CPRI was given the mandate to provide assessment services to children/youth, ages 6-18 years who exhibited sexual behaviour concerns. A thorough literature review was conducted to help inform clinicians of various disciplinary backgrounds (i.e., psychology, social work, psychiatry, nursing, behavioural consultation, and play and art therapy) on best-practice guidelines for treating children/youth with ISB. A multidisciplinary team was created to develop the SBT; servicing a wide range of clients with complex mental health needs.

SBT at CPRI. The SBT involves a collaborative treatment model developed to provide assessment, consultation, and education to the client, client's family, and home community. According to Stewart and Marshman (2010), specialized treatment approaches that address unique factors at the client, family, and community level have been found to reduce ISB in children/youth (e.g., Henggeler et al., 2009). The SBT has been providing service since 2007 and is now conducting a program evaluation seeking implications for further prevention and advancement in terms of assessment, treatment, and ongoing safety of these children/youth. Findings of this project will contribute to more informed approaches to assessment and intervention within the SBT services. For example, improvements in client functioning as a result of assessment or treatment recommendations will serve to heighten awareness around current practices and service delivery.

Measures

Brief Child and Family Phone Interview (BCFPI; Cunningham, Pettingill & Boyle, 2004). The BCFPI provides a measure of the type and severity of children/youth's problems. It is a standardized interview consisting of 81 forced-choice questions and remains the mandated intake measure used by all Children's Mental Health Centres in the Province of Ontario. Five broadband subscales (e.g., *Externalizing; Internalizing; Total of 6 Mental Health Domains; Global Functioning and Global Family Situation*) are measured using normative *t*-scores. Internal consistency scores indicate adequate reliability; especially given that brief screening consists of few items per factor. The content validity of this measure is reported to be based on the mapping of items to the Diagnostic and Statistical Manual of Mental Health Disorders criteria. The BCFPI manual reports research into the criterion validity of this measure focusing on relationships between subscales.

Behavioural and Emotional Rating Scale—Second Edition Parent Rating Scale (BERS-2P; Epstein, 2004). The BERS-2P is a measure of strengths and competencies for children covering the domains of *Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, and Affective Strength*. It is conducted with children/youth between the ages of 5-18 years and contains 52 items. There is also a 5-item *Career Strength* subscale for older youth. Scores can be used to identify target areas for interventions, set goals for educational, mental health, and social work treatment plans and monitor progress towards goals. The internal consistency reliability of the BERS-2P subtests was established with children without disabilities and with children who were emotionally disturbed. Coefficients exceeded .80 for each subtest and .95 for the overall score. Over 15 studies have confirmed the BERS-2P content, construct, and criterion-related validity.

Child Behavior Checklist (CBCL; Achenbach, 1992). The CBCL is a widely used checklist for the assessment of children's behavioural and emotional problems. The CBCL yields *Internalizing* and *Externalizing* scale scores, as well as a Total score. Parents/caregivers are asked to respond to each item as "*not true*", "*sometimes true*", or "*very true*", as it pertains to the child during the past 2 months. The CBCL is reported to have good psychometric properties and has been identified as the "Gold Standard" in the assessment of children/youth with behaviour and socio-emotional problems (Achenbach & Rescorla, 2000).

Procedure

Once a referral was made for a client to attend the SBT services at CPRI, a pre-admission package was mailed to the client's guardian for completion prior to receiving any services. This package included the CBCL (6-18 years) and BERS-2P. A trained intake employee contacted families to collect BCFPI data via phone contact. A "meet and greet" was then scheduled where a clinician collected informed consent/assent to research (see Appendices A through E). As packages were completed and returned to the SBT research team, measures were scored and entered into an SPSS database for analyses. While all measures utilized are subject to inaccurate data collection due to their self-reported nature, other threats to internal validity were controlled for due to measuring participants solely at admission; these include: maturation, instrumentation, testing, expectancy, and experimental mortality.

Statistical Analyses

Binomial logistic regression models were conducted to determine which combination of investigated traits best discriminate between children/youth who offend—both sexually and non-sexually—and those who do not. Determining odds ratios to identify relative strengths in categorical predictions are helpful when informing treatment philosophies tailored towards individual client needs. Further, servicing children/youth most appropriately holds the potential for reducing rates of victimization as cost-effective programming and resources can be incorporated. It was expected that once predictions are made about ISB in offending children/youth, treatment efforts can be focused on specific high-risk characteristics that are indicative of such behaviour. These analyses should result in the most parsimonious model and further enable emphasis on mitigating barriers to long-term treatment success.

Results

For the purposes of analyses, a sexual offense was defined as a client's physical contact with another person that is uninvited and deemed sexual in nature. A non-sexual offense was defined as a chargeable offense regardless of the status of the involvement of the legal process (i.e., being caught, adjudicated, or non-adjudicated) and includes threats or threatening behaviour, cruelty to animals, use of weapons to intimidate or hurt others, vandalism, theft, breaking and entering, and so forth.

Due to a common occurring attrition rate within clinical samples, not all administered measures were completed by each client. In each case, multivariate analysis of variance was used to account for descriptive differences between those who completed each measure and those who did not. Incorporating a conservative Bonferroni correction ($p < .01$), no significant descriptive differences were found across groups for age, gender, functioning ability, income,

single or dual parenting, experiences of sexual abuse, history of non-sexual abuse, or offending patterns suggesting that the sample in both groups were similar for the purposes of interpretation.

Hypothesis 1

Model 1: Family Involvement. To measure the level of family involvement for each child/youth, *Separation of Parent* scores on the BCFPI and *Family Involvement* scores on the BERS-2P were compared across groups for those clients who sexually offended against others versus those who did not.

A binomial logistic regression model was performed with sexual offending as the dependent variable, and parent separation and family involvement as predictor variables. A total of 23 cases were analysed. The model did not significantly predict sexual offending status (omnibus chi-squared = 3.68, df = 2, *ns*). This means that clients' level of family involvement could not accurately predict whether they would sexually offend against others (see Table 2 for coefficients and values).

Model 2: Living Environment. Measuring a client's adversity within the living environment was operationalized by comparing *Global Family Situation* scores on the BCFPI, types of non-sexual abuse experienced by the child/youth (e.g., physical and/or emotional), and the reported income for each family (e.g., less than $30,000 per year, between $30,000-$60,000 per year, and over $60,000 per year).

With sexual offending as the dependent variable and family situation, non-sexual abuse, and income as predictor variables, a total of 32 cases were analysed. The model approximated significance (omnibus chi-squared = 11.20, df = 6, $p = 0.08$). The model accounted for between 29.5% and 40.2% of the variance in sexual offending status, with 80.0% of those who sexually offended against others successfully predicted. Prediction for those who did not offend others

was only 58.3%. Overall 71.9% of predictions were accurate. The values of the coefficients in Table 2 reveal that only Abuse reliably predicted sexual offending status whereby those who experienced both physical and emotional abuse were associated with a significant decrease in the odds of sexually offending others by a factor of 0.067 (95% CI 0.01—0.67).

Model 3: Sexual Victimization. A client was identified as having been "sexually victimized" if caregivers reported any history of sexual abuse experienced by their child/youth. Severity of a child/youth's sexual victimization was not accounted for due to the difficulty in determining the impact of various sexual experiences across victims. Therefore, only a "*yes*", "*no*", or "*don't know*" were indicated for each client in response to whether or not caregivers believed their child to have been sexually abused.

A binomial logistic regression was performed with sexual offending as the dependent variable and sexual abuse history as the predictor variable. In total, 78 cases were analysed and the model significantly predicted sexual offending status (omnibus chi-squared = 9.83, df = 2, $p < 0.01$). The model accounted for between 11.8% and 16.2% of the variance in sexual offending status, with 73.5% of those who victimize others successfully predicted. However, only 55.2% of predictions for the non-victimizers group were accurate. Overall 66.7% of predictions were accurate. The values of the coefficients in Table 2 reveal that the occurrence of sexual victimization in a child/youth's past is associated with a significant decrease in the odds of sexually offending others by a factor of 0.18 (95% CI 0.06—0.57).

Hypothesis 2

Model 4: Alternate Forms of Abuse. Similar to the living environment model, a client was identified as having experienced alternate forms of abuse if the caregiver reported any history of non-sexual abuse (i.e., physical and/or emotional). History of abuse was compared between two types of offenders in the sample for those who offended sexually versus those who offended both sexually and non-sexually.

Fifty cases were analysed and abuse significantly predicted type of offending (omnibus chi-squared = 12.93, df = 3, $p < .01$). The alternate forms of abuse accounted for between 22.8% and 31.0% of the variance in offending behaviour, with 68.4% of those who offended sexually alone successfully predicted. Of those who offended both sexually and non-sexually, 80.6% of the predictions were accurate. Overall, 76.0% of the predictions were accurate. The values of the coefficients in Table 3 reveal that those who were reported to have experienced both "physical and emotional abuse" reliably predicted type of offending in that their odds of offending both sexually and non-sexually significantly decreased by a factor of 0.08 (95% CI 0.01—0.46).

Model 5: Conduct Related Problems. Conduct related problems were assessed using the *Externalizing* scale on the CBCL and compared between two types of offending groups.

A binomial logistic regression model was performed with the type of offending as the dependent variable and externalizing behaviour as the predictor variable. Thirty cases were analysed and the model significantly predicted type of offending (omnibus chi-squared = 3.83, df = 1, $p = .05$). The model accounted for between 12.0% and 16.4% of the variance in offending behaviour, with 84.2% of those who offended both sexually and non-sexually successfully predicted. However, only 36.4% of predictions for those who offended sexually alone were

accurate. Overall 66.7% of predictions were accurate. The values of the coefficients in Table 3 reveal that externalizing behaviour reliably predicted type of offending with approximated significance (p = .07). An increase of one standard deviation on the *Externalizing* scale of the CBCL was associated with an increase in the odds of offending both sexually and non-sexually by a factor of 1.11 (95% CI 1.00—1.91)

Post Hoc Analyses

In order to gain a better understanding of offending behaviour, post hoc analyses were conducted to incorporate demographic data collected during assessment. Age, gender, and functioning challenges were assessed in accordance with sexual offending (i.e., whether these variables were predictive of those who sexually offended compared to those who did not at the time of admission), as well as with offending patterns (i.e., whether these variables were predictive of those who offended sexually compared to those who offended both sexually and non-sexually at the time of admission).

Model 6: Sexual Offending. A binomial logistic regression was performed with sexual offending as the dependent variable and age, gender, and functioning challenges (i.e., mental health or developmentally delayed) as predictor variables. Seventy-six cases were analysed and the model significantly predicted type of offending (omnibus chi-squared = 17.14, df = 3, p = .001). The model accounted for between 20.2% and 27.4% of the variance in offending behaviour, with 89.4% of those who sexually offended others successfully predicted. Overall 72.4% of predictions were accurate. The values of the coefficients in Table 4 reveal that both age and gender reliably predicted sexual offending status. With each additional year in age, the odds that a child/youth would sexually offend was significantly increased by a factor of 1.267

(95% CI 1.02—1.58). Also, males were more likely than females to sexually offend by a factor of 6.162 (95% CI 1.44—26.30).

Model 7: Offending Patterns. A binomial logistic regression model was performed with the type of offending as the dependent variable and age, gender, and functioning challenges as predictor variables. Fifty-seven cases were analysed and the model significantly predicted type of offending (omnibus chi-squared = 13.20, df = 3, $p < .01$). The model accounted for between 20.7% and 27.8% of the variance in offending behaviour, with 93.9% of those who offended both sexually and non-sexually successfully predicted. However, only 37.5% of predictions for those who offended sexually alone were accurate. Overall, 70.2% of the predictions were accurate. The values of the coefficients in Table 4 reveal that males reported significantly more likely than females to offend both sexually and non-sexually by a factor of 15.41 (95% CI 1.72—137.66). Age and Functioning were not, however, significantly predictive of a child/youth's offending pattern.

Overall, findings suggest that participants who had sexually offended others at the time of assessment were more likely to be older males with fewer reports of personal abuse (i.e., physical, emotional, and/or sexual) suggesting that trauma may play a mediator role to sexual offending patterns. Also, children/youth that were reportedly engaging in both sexual and non-sexual offending behaviours tended to exhibit greater levels of conduct related problems and were more likely to be males.

Discussion

The current study was an exploratory investigation of a specialized assessment program for intervention with children/youth who exhibit ISB. The primary purpose of this research was to identify trait differences in offending patterns between children/youth who sexually victimize others and those who do not sexually victimize others. Participants of various backgrounds and personal victimization experiences were clinically-referred to the SBT for treatment of concerning sexual behaviour and risk factors were assessed in areas such as family involvement, living environment, abuse, conduct related problems, age, gender, and functioning challenges. Implications of these findings are discussed in relation to their future impact on assessment and informed treatment and how predictive risk factors can be used to develop strategies that help to reduce further sexual victimization.

Family involvement. Caregiver responses were compared using *Separation of Parent* scores on the BCFPI and *Family Involvement* scores on the BERS-2P. It was predicted that a lack of family involvement would be more prevalent among children/youth who have sexually offended against others compared to those who have not. However, this finding was not supported and indicates that family involvement is not a predictive factor of sexual offending in this sample.

Results do not indicate, however, the valence of family involvement within participating families, but rather that no discerning characteristics are present between the children/youth assessed. This implies that family involvement may still be an area of concern for these children/youth; however, it does not distinguish risk factors predictive of their sexual conduct. It may be that all of the families within the current sample were of such high risk that they represent the skewed proportion of the distribution of overall family functioning.

In contrast, it is possible that, given the families' engagement in tertiary mental health services, family involvement presents as adaptive since treatment at this level requires caregivers to be collaborative within their children's treatment progress—even if only transporting them to and from appointments. Caregiver supervision of children/youth within the home often increases in response to escalated conduct behaviours. Additionally, fruitless experiences with previous services may elicit caregivers to report their family's involvement as exhaustive and unconditionally supportive.

Living environment. Comparisons were made across *Global Family Situation* scores on the BCFPI, types of non-sexual abuse experienced by the child/youth (e.g., physical and/or emotional), and the reported income for each family. It was predicted that an increased risk of sexual offending would accompany adverse living environments such as with family dysfunction or poverty. While findings did not support the hypothesis as stated, results indicate that non-sexual abuse status was helpful in predicting less sexually offensive behaviour in children/youth. Those who had reportedly experienced both physical and emotional abuse were less likely to sexually offend others compared to those with no reported physical or emotional abuse.

Since caregivers may play a common role in the physical and/or emotional abuse that is committed against their children/youth—either through active involvement or failure to protect—it is possible that reports of abuse are at a heightened susceptibility for misrepresentation. For example, abusive caregivers may not fully understand the impact that their actions have towards their children; in which case caregivers might under-report for lack of awareness. Additionally, caregivers who suffered abuse themselves at a young age may consider certain levels of family dysfunction as "normal" and may minimize any of their own maltreatment towards others. Consequently, caregivers may be completely aware of their

actions, but hesitate to disclose due to feelings of shame, embarrassment, or fear that child protective services will become involved.

Conversely, if caregivers have exhausted all of their resources in seeking help for their family, they may over-pathologize their children's circumstance in order to secure treatment. In an attempt to justify their child's inappropriate behaviour, caregivers may over-report suspicion of maltreatment in order to place blame for their child's problematic disposition.

Sexual Victimization. The occurrence of each child/youth's personal experience with sexual abuse was documented through caregiver disclosure on the BCFPI. It was anticipated that a child/youth's history of sexual abuse would be a predictive risk factor of their sexual offending behaviour towards others. This finding was not supported. In contrast, a history of sexual abuse was found to significantly decrease a child/youth's odds of sexually offending.

These findings challenge the victim-perpetrator theory (Burton, 2003) which suggests that victims of sexual abuse engage in future perpetrating roles towards others. Consequently, further support is given to prior studies (e.g., Salter et al., 2003; Paolucci, Genuis, & Violato, 2001; Wood, Grossman, Fichtner, 2000) which indicate that the majority of victims do not go on to offend against others. Follow-up assessment of this population may be beneficial in order to maintain these findings in case sexualization manifests differently over time.

Alternate forms of abuse. Types of non-sexual abuse (i.e., physical and/or emotional abuse) were documented, again, through caregiver disclosure on the BCFPI. With respect to offending patterns, it was hypothesized that children/youth who offend both sexually and non-sexually would report more experience with alternative forms of abuse than those who offend sexually alone. This finding was not supported. In contrast, a child/youth's history of both physical and emotional abuse significantly decreased the likelihood that he or she offended both

sexually and non-sexually. This means that the greater the severity of non-sexual abuse experienced, the less likely a child/youth was to engage in antisocial behaviours involving both sexual and non-sexual tendencies; the breadth of offending behaviour decreased as the breadth of abuse experienced increased.

Implications of these findings suggest that alternate forms of motivation may be inherent in more pervasive offending patterns. Children/youth that are offending both sexually and non-sexually are experiencing urges to do so that appears independent from their own history of abuse. Other contributing variables may be more discrete or contextual (see Implications for Treatment below).

Conduct related problems. Comparisons were made across the *Externalizing* scale of the CBCL. It was presumed that greater levels of conduct related problems, such as externalizing behaviour, would exist at a higher rate for those who offended both sexually and non-sexually compared to those who offend sexually alone. Results approximated significance in support of this prediction. With each standard deviation increase on their *Externalizing* scores, the odds of children/youth committing offenses both sexual and non-sexual in nature increased by 11%.

Age, Gender, Functioning. Remaining demographic information was incorporated to explore post hoc analyses. First, age, gender, and functioning challenges (i.e., MH or DD) were used as predictive variables in deciphering between children/youth who sexually offended others and those who did not. Next, these same three predictive variables were used in deciphering those who offended sexually versus those who offended both sexually and non-sexually.

While functioning was not identified as a risk-factor in either case, age and gender elicited informative outcomes. As children/youth's ages increased by 1 year, their odds of

sexually offending someone increased by approximately 27%. Also, males were found six times more likely to sexually offend than females. With respect to offending patterns, gender was the only significant predictor. Males were 15 times more likely than females to offend both sexually and non-sexually. These results are similar to Bonner, Walker, and Berliner's (1999) initial findings for their aggressive sub-group typology of offenders.

While the current sample is disproportionately male (83.8%), results imply that older males pose a greater risk of sexually offending. It is curious as to how much of this pattern is indicative of a false understanding of sex-roles in society by these individuals. For example, if males are perceived as the sexual aggressors and/or have witnessed such behaviour modelling by other males, they may be susceptible to inappropriate re-enactment or coercion; especially if modelled by an authoritative figure in their lives.

In contrast, it is curious as to how intervention needs pertaining to females is recognized. More specifically, if females manifest the effects of early sexualization differently—perhaps more covertly—than males who tend to externalize much of their behaviour, is there an imbalance of treatment efforts in favour of rehabilitating males? While emphasis is put on reducing sexual victimization in general, the need for early intervention of those exhibiting ISB regardless of their offending patterns is pertinent in preventing the negative impacts of ISB. Therefore, the needs for proactive intervention is important to address across both genders and future directions should consider possible differences in assessment or treatment approaches.

Limitations

It should be noted that all data in this study was obtained from a single tertiary agency which limits the generalizability of the current findings. More specifically, results might be less relevant to populations that do not contain children/youth with highly complex, co-morbid mental health problems, or to those experiencing a specific aggregated burden of risk. Discretion needs to be taken when applying the current findings to less severe clinical populations. Similarly, given the high-risk nature of clients seeking services with CPRI, differences between participants may be more discrete than the current analyses accounted for; especially considering sample size limitations. Further investigation is necessary to identify supplementary traits that distinguish between those exhibiting different types of offending patterns.

Additionally, data was gathered solely from a caregiver's perspective with no alternative sources of collateral information to compare findings. Therefore, data may be subject to inaccuracies for a number of reasons. First, it may be that caregivers are not entirely familiar with their child's history around sexual experience or involvement with others. In the event that a child/youth was sexually victimized, it is possible that disclosure is withheld out of fear of repercussions, discomfort with confusing emotions associated with experiences (i.e., shame, guilt, anger, anxiety, and so forth), or stigma surrounding victims of sexual abuse. Second, in the event that a child/youth has not experienced their own victimization, but has been sexually involved with others at an inappropriate age, it may be that these behaviours are engaged in covertly in order to ward off disciplinary interventions by caregivers. While no predictive differences were found across participants or by a lack of family involvement, it could be the case that less involved parents may not be privy to this information due to the distance in their relationship with the child/youth.

Alternatively, caregivers may be aware of their child's level of sexual involvement, but under- or over-pathologize their child's symptoms. For example, caregivers may experience their own confusion with emotions or stigma associated with their child's ISB and, thus, filter their decisions to disclose on behalf of the child/youth. It is also possible that a caregiver's inability to accept their child's experiences—through denial—may affect their accurate reporting. In contrast, given that the current sample was seeking intervention at a tertiary mental health facility, the likelihood that families have exhausted their resources for help is heightened. This means that caregivers might over-emphasize their child's needs in order to ensure that treatment and intervention efforts are secured.

Lastly, throughout data collection of each child/youth's abuse history, no definition was provided to respondents as to what actually constitutes abuse; caregivers were merely asked to respond "*yes*", "*no*", or "*I don't know*" to whether or not their child had been sexually abused, emotionally abused, or physically abused. It is possible that if caregivers maintained a different definition of the term "abuse", then they might be inconsistently reporting their child's experiences. A child/youth who has been exposed to sexual content unwillingly (e.g., by sexual language, pornography or exposure to others' body parts) for pleasure by a perpetrator would still be considered to have suffered the effects of sexual abuse despite not having been physically involved. Similarly, if caregivers define adult-child sexual involvement as abuse, but peer-peer sexual involvement as "normal experimental behaviour", there may be an under-representation of victimization within the sample; especially given that sexual offending between juveniles remains a prominent concern as illustrated in the literature. Such differences in awareness or definitions could elicit differences in reporting and ultimately affect assessment outcomes.

Implications for Treatment

Despite the limitations of the study, a number of implications for future assessment and treatment are notable. First, in response to whether or not their child/youth had ever experienced sexual abuse, many caregivers (21%) reported that they did not know. While this may reflect the limitations to definitions provided about what constitutes "sexual abuse", it may also be indicative of a family's lack of involvement or adverse living environments. If caregivers do not know their child's history of sexual abuse because they remain less engaged with their child, this could be indicative of an area lacking in family support.

Similarly, if caregivers ascertain a consistent level of family involvement, but still do not know for certain whether or not their child has experienced sexual abuse, this could be indicative of a caregiver's awareness that his or her child has been exposed to an environment where sexual abuse cannot be ruled out with confidence. In either case, caregiver responses of "*I don't know*" should be followed up on in assessment and may be an area of priority to explore in treatment. Uncertainty of this information may elicit unforeseen stress within families—further contributing to dysfunction within the home environment. Therefore, supplementary counselling and psychoeducation for caregivers may be effective in ameliorating their own challenges while they support their child through treatment for ISB. Since a caregiver-child relationship is reciprocal in nature, supporting both parties will help to facilitate long-term treatment outcomes.

Second, given that sexual offending behaviour was less likely exhibited by children/youth with histories of abuse (sexual and non-sexual), other sexualizing influences may play a role. More specifically, children/youth that experience traumatic feelings during sexual abuse—such as a result of force, coercion, injury, and so forth—may be less inclined to inflict similar feelings on others through victimization. Perhaps such blatant trauma enables their ability to empathize

with others given a heightened sense of self-awareness. In this instance, trauma may act as a mediator for sexual offending and should be fully assessed for at the start of intervention.

Other sexualizing influences, however, may be encountered in a less threatening manner. For example, with the prevalence of peer to peer sexual offending, it is possible that while many of the children/youth's actions are classified as "sexual abuse", victims' awareness may not reflect their interpretation of such behaviours as abusive. Further, a child/youth who is peer-pressured into a sexual act that others they socialize with are engaging in may not feel as guilty for the behaviour despite its age-inappropriateness. Their acceptance within a group of similarly engaging peers may be solidarity enough to deem the sexual behaviours as "normal". Hence, their understanding of soliciting others sexually may seem innocuous to them given their peer support.

It may also be that in a circumstance where children/youth are not engaging personally in ISB, being a member of a group where others use sexual language, objectify peers for sexual purposes, expose pornographic material to friends, or ostracize others for lack of sexual experience, could sexualize a child/youth vicariously through a peer's experiences or behaviours. This form of "vicarious sexualization"—a term which will be used in the following section—could also be experienced within the home by way of caregivers or older siblings. Examples include the use of inappropriate language, behaviour, or attire; witnessing a single-caregiver or sibling with multiple partners; exposure to age-inappropriate media or discussions; and so forth.

Vicarious sexualization of a child/youth is concerning; it often occurs in the absence of social reasoning. Therefore, children/youth do not fully internalize the boundaries inherent in appropriate social skills. Moreover, sexualization amongst peers may be an outlet through which children/youth can experience being "grown up" or in control given its association with more

adult-like behaviour. If a child/youth has experienced sexual abuse them self, he or she does not have to physically contact other individuals in order to vicariously sexualize them. In this situation, vicariously sexualizing acts may be overlooked as abusive or inappropriate. In relation to the discussion above regarding differences in gender manifestations, it could be the case that females who have experienced early sexualization express their ISB in more subtle ways to others (i.e., through language, choice of attire, early invitations to engage in sexual acts, and so forth). Such an approach could be deemed a more passive social role and easily overlooked as a contributor to the cycle of vicarious sexualization.

As this pertains to intervention, inquiries around clients' peer groups and what they deem as "normal" may be informative to the assessment process. Again, clear definitions of sexualizing behaviour should be conveyed to all informants. Access to information regarding age of onset for sexual behaviour or knowledge and the prevalence of sexual involvement within a client's circle of peers may be useful in an improved understanding of risk factors and tailoring treatment. Treatment of vicarious sexualization should emphasize social skills building and education regarding boundaries, victim awareness, and sexual safety.

Third, while the majority of the current sample (94%) reportedly participated in offending behaviour of some kind—either sexual or non-sexual—those who exhibited increased levels of conduct related problems tended to be male and were engaging in both sexual and non-sexual offenses. Future assessments with clients exhibiting ISB should consider the aggregated burden of risk presented with an older male, displaying high externalizing scores, with a history of fewer traumatic experiences in regards to future victimization. Treatment for these particular cases may require more intensive and/or holistic interventions to ensure that recidivism is

reduced and appropriate resources are available to support these youth as they continue to develop.

Future Directions

In order to appreciate the manifestations of long-term ISB, longitudinal studies should be considered; especially with respect to clarifying theories of victim-perpetrator behaviour. While follow-up data can be informative in further tailoring treatment approaches, it can also be effective in identifying retrospective risk factors in the event that an historical disclosure is made about a previous study participant. Also, if offending patterns change across time, future research in this area would be important to promote effective services more proactively.

While incorporating multiple informants (e.g., self-report, clinicians, teachers) within ISB assessments would be helpful in gaining a more holistic understanding of a participant, providing clear definitions of characteristics is also critical in maintaining a standardized approach to data collection. Consistent language between respondents and clinicians would ensure a more accurate analysis of trait differences within the findings.

Additionally, future research into the severity of sexual abuse experiences may help to clarify connections between trauma and sexual offending. It may also help to define what constitutes a proper case, if clients of similar experiences or behaviours are compared in isolation. It remains difficult to measure risk factors if a client presents with a wide spectrum of ISB concerns; future investigations may be more informative if the sample population is first categorized into typologies.

Lastly, investigating possible patterns between caregivers' own histories of abuse and their children/youth's experience may help to further understand the avenues of sexualization or maltreatment within their living environments. Also, incorporating data collection regarding a

client's peer group may provide a better comprehension of external influences in order to reduce vicarious sexualization and victimization.

Conclusion

In summary, primary findings from this study suggest that children/youth who sexually offend may be influenced by factors unrelated to their own history of sexual, physical, and emotional abuse. Demographic information such as age and gender may play an informative role in offending patterns and, coupled with elevated externalizing scores, could create an aggregated burden of risk in certain children/youth exhibiting ISB. Findings from this study will assist in evidence-based assessment within service delivery and enhance long-term treatment success for children/youth with premature sexualization. Effective changes in intervention for inappropriate sexual behaviour will increase the use of cost-effective treatment approaches; thus, providing quicker access to services and harm reduction with respect to future victimization or recidivism. Future directions should be considered to advance understanding in this area.

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Table 1

Overview of sample descriptives.

	N	%
Gender Distribution		
Male	67	83.80
Female	13	16.30
Type of Functioning Difficulty		
Mental Health	56	71.80
Developmental	22	28.20
Living Arrangement (n = 44 respondents)		
Single parent	19	43.20
Spouse or partner	25	56.80
Family Income % (n = 36 respondents)		
< $30, 000	16	20.00
$30,000 to $60,000	7	8.80
> $60, 000	13	16.30
Victimized (sexually abused)		
Yes	33	42.30
No	29	37.20
Don't know	16	20.50
Other Abuse (*n* = 70 respondents)		
None reported	21	30.00
Physical	7	10.00
Emotional	13	18.60
Both Physical & Emotional	24	34.30
Offender		
No	5	6.30
Sexual	14	17.50
Non-sexual	25	31.30
Both Sexual & Non-sexual	36	45.00

Table 2

Binomial logistic regression analyses using models: Family Involvement, Living Environment, and Sexual Victimization.

	B	SE	Wald	df	Exp(B)
Model 1: Family Involvement (*n* = 23)					
BCFPI: Separation of Parents	-0.480	0.033	2.117	1	0.954
BERS-2P: Family Involvement	0.081	0.075	1.171	1	1.084
Model 2: Living Environment (*n* = 32)					
BCFPI: Global Family Situation	0.025	0.021	1.402	1	1.025
Abuse (none) REFERENCE			6.020	3	
Abuse (physical)	-0.057	1.429	0.002	1	0.945
Abuse (emotional)	0.110	1.269	0.008	1	1.116
Abuse (physical & emotional)	-2.697	1.173	5.284	1	0.067*
Income (< $30K/yr) REFERENCE			2.819	2	
Income ($30-$60K/yr)	2.201	1.526	2.078	1	9.030
Income (> $60K/yr)	1.485	1.103	1.812	1	4.414
Model 3: Sexual Victimization (*n* = 78)					
Sexual Abuse History ("*no*") REFERENCE			8.705	2	
Sexual Abuse History ("*yes*")	-1.712	0.586	8.539	1	0.181**
Sexual Abuse History ("*don't know*")	-1.253	0.677	3.429	1	0.286†

*$p < .05$. **$p < .01$. ***$p < .001$.
† $p < .10$ (approximated significance)

Table 3

Binomial logistic regression analyses using models: Alternate Forms of Abuse, and Conduct Related Problems.

	B	SE	Wald	df	Exp(B)
Model 4: Alternate Forms of Abuse (n = 50)					
Abuse (none) REFERENCE			10.923	3	
Abuse (physical)	-0.182	1.335	0.019	1	0.833
Abuse (emotional)	-0.811	1.021	0.631	1	0.444
Abuse (physical & emotional)	-2.565	0.909	7.956	1	0.077**
Model 5: Conduct Related Problems (n = 30)					
CBCL: Externalizing	0.107	0.059	3.314	1	1.113†

*$p < .05$. **$p < .01$. ***$p < .001$.
† $p < .10$ (approximated significance)

Table 4

Post hoc binomial logistic regression analyses using models: Sexual Offending, and Offending Patterns.

	B	SE	Wald	df	Exp(B)
Model 6: Sexual Offending (*n* = 76)					
Age	0.237	0.111	4.536	1	1.267*
Gender (female) REFERENCE					
Gender (male)	1.818	0.740	6.032	1	6.162*
Functioning (MH) REFERENCE					
Functioning (DD)	1.040	0.659	2.488	1	2.828
Model 7: Offending Patterns (*n* = 57)					
Age	0.124	0.132	0.887	1	1.132
Gender (female) REFERENCE					
Gender (male)	2.735	1.117	5.991	1	15.408*
Functioning (MH) REFERENCE					
Functioning (DD)	1.091	0.773	1.990	1	2.976

*$p < .05$. **$p < .01$. ***$p < .001$.
MH = mental health challenges
DD = developmental delay challenges

APPENDIX A

Ministry of Children and Youth Services

CPRI
600 Sanatorium Road
London ON N6H 3W7
Tel: (519) 858-2774
Fax: (519) 858-3913
TTY: (519) 858-0257

CPRI
600 Chemin Sanatorium
London ON N6H 3W7
Tel: (519) 858-2774
Téléc.: (519) 858-3913
ATME: (519) 858-0257

Ministère des Services à l'enfance et à la jeunesse
Ontario

Letter of Information for Youth (13+ years)

CPRI Sexual Behaviour Team: Reduction of sexually inappropriate behaviours in children and youth with mental health and developmental difficulties.

What is the purpose of this study?
We are evaluating the Sexual Behaviour Team at CPRI. We want to find out if the Team helps children and youth with sexual behaviour problems and their families.

Who are the investigators?
Dr. Shannon Stewart is a Psychologist and the Manager of Applied Research and Education at CPRI. Mary Ellen Marshman is a Psychometrist and the Clinical Lead of the Sexual Behaviour Team.

What will happen in this study?
To find out if the Team is helpful, we will use the information collected during the assessment and compare it with more information that will be gathered later. We will also ask you questions about your satisfaction with the assessment and services. This will help us to know what we are doing well and how we can make our services better.

Is participation voluntary?
You do not have to participate if you do not want to. You can also change your mind later. The Team will still do the same assessment and give suggestions to you and your family even if you do not want your information to be used for the study.

Will my information be kept private?
If you choose to let your information be used for the study it will still be kept private. All of the completed forms will be stored in a locked file at CPRI. Your name will not be included with the information which is entered into a computer database for the study. This database will be destroyed ten years after you turn 18 years old, as stated in the Child and Family Services Act. If the results of this study are published, your name will never be used and no identifiable information will be released or published. The information gathered will be analysed on a group-wide basis, not individually.

What are the risks?
There are no known risks if you allow the information collected to be used for the program evaluation study.

What are the benefits?
There are no direct benefits to you from participating in this program evaluation. But it could help other children and families with the same problems later if we find we need to make our services better.

Any Questions?
If you have any questions about this study, please contact Dr. Stewart, [redacted] ext. [redacted] or Mary Ellen Marshman, [redacted] ext. [redacted]. If you have any questions about your rights as a research participant, you may contact the Office of Research Ethics at the University of Western Ontario, 519-661-3036.

APPENDIX B

Ministry of Children and Youth Services

CPRI
600 Sanatorium Road
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Tel: (519) 858-2774
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CPRI
600 Chemin Sanatorium
London ON N6H 3W7
Tel: (519) 858-2774
Téléc.: (519) 858-3913
ATME: (519) 858-0257

Ministère des Services à l'enfance et à la jeunesse
Ontario

Consent Form for Youth (13+ years)

CPRI Sexual Behaviour Team: Reduction of sexually inappropriate behaviours in children/youth with mental health and developmental difficulties

Investigators: Dr. Shannon L. Stewart, Ph.D., C.Psych
Mary Ellen Marshman, MSc.

I have read the letter of information, the nature of the study has been explained to me and I agree to participate. All questions have been answered to my satisfaction.

I have received a copy of the Letter of Information.

_____	_____	_____
Youth Signature	Print Name	Date
_____	_____	_____
Person Obtaining Consent Signature	Print Name	Date

APPENDIX C

Ministry of Children and Youth Services

CPRI
600 Sanatorium Road
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CPRI
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Tel: (519) 858-2774
Téléc.: (519) 858-3913
ATME: (519) 858-0257

Ministère des Services à l'enfance et à la jeunesse
Ontario

Letter of Information for Parents

CPRI Sexual Behaviour Team: Reduction of sexually inappropriate behaviours in children and youth with mental health and developmental difficulties.

What is the purpose of this study?
We would like to invite you to participate in a program evaluation of the Sexual Behaviour Team at the Child and Parent Resource Institute. This study will use information that is gathered as part of the Sexual Behaviour Team's standard assessment and consultation services. The information collected will be used to evaluate the effectiveness of our assessment and consultation services in reducing concerning sexual behaviours of children/youth.

Who are the investigators?
Dr. Shannon Stewart is a Psychologist and the Manager of Applied Research and Education at CPRI. Mary Ellen Marshman is a Psychometrist and the Clinical Lead of the Sexual Behaviour Team.

What will happen in this study?
By signing the attached consent form you will allow the Sexual Behaviour Team to use the information collected during the assessment for the program evaluation study. We will also ask you questions about your satisfaction with the assessment and services we provided to you.

Is participation voluntary?
Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions, or withdraw from the study at any time. Refusal to participate will have no effect on the services you receive at CPRI. **Please note: you will still be asked to complete all of the questionnaires for use in your child/youth's assessment. You have a choice as to whether you allow this information to be used for research purposes.** If you do not wish to participate in this study you will receive the standard assessment, and we will not use the data for research.

How will confidentiality be ensured?
If you choose to participate in this study all of the information gathered will still be kept private. All of the completed forms will be stored in a locked file at CPRI. Neither you nor your child/youth's name will be included with the information which is entered into a secure electronic database for research purposes. This database will be destroyed ten years after your child/youth turns 18 years old, as stated in the Child and Family Services Act. If the results of

this study are published, neither your name nor your child/youth's name will ever be used, and no identifiable information will be released or published. The information gathered will be analysed on a group-wide basis, not individually.

What are the risks?
There are no known risks or discomforts associated with allowing the information collected to be used for program evaluation purposes.

What are the benefits?
There are no direct benefits to you or your child/youth from participating in this program evaluation. However, this evaluation could lead to improvement in the services offered by the Sexual Behaviour Team which could benefit future clients and their families.

Any Questions?
If you have any questions about this study, please contact Dr. Stewart, [redacted] ext. [redacted] or Mary Ellen Marshman, [redacted] ext. [redacted]. If you have any questions about your rights as a research participant, you may contact the Office of Research Ethics at the University of Western Ontario, 519-661-3036.

APPENDIX D

Ministry of Children and Youth Services

CPRI
600 Sanatorium Road
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Téléc.: (519) 858-3913
ATME: (519) 858-0257

Ministère des Services à l'enfance et à la jeunesse
Ontario

Consent Form for Parent/Guardian

CPRI Sexual Behaviour Team: Reduction of sexually inappropriate behaviours in children/youth with mental health and developmental difficulties

Investigators: Dr. Shannon L. Stewart, Ph.D., C.Psych
Mary Ellen Marshman, MSc.

I have read the letter of information, the nature of the study has been explained to me and I agree to participate. All questions have been answered to my satisfaction.

I have received a copy of the Letter of Information.

_____	_____	_____
Parent/Guardian Signature	Print Name	Date

_____
Child/Youth's Name

_____	_____	_____
Person Obtaining Consent Signature	Print Name	Date

APPENDIX E

CPRI
SEXUAL BEHAVIOUR TEAM
Promoting Safety and Sexual Health

Assent for Child Under 12
Program Evaluation of the Sexual Behaviour Team

Who is doing this?

Dr. Shannon Stewart, Mary Ellen Marshman, and other Sexual Behaviour Team members

What is this program evaluation?

This is a study to help us know if the assessment and suggestions from the Sexual Behaviour Team are really helpful for children and teens with sexual behaviour problems and their families.

What do you need to do?

We'd like your opinion. At the end of the assessment we will ask you to fill out a form to let us know how satisfied you were with the team and your assessment. Other than that, you do not need to do anything extra for this study. To find out if the Team is helpful we will use the information that the Team gathers for your assessment and compare it with more information that will be gathered later. This will help us to know what we are doing well and how we can make our services better. All of your answers and other information about you will be kept private.

Will this help you?

Being part of this study will not change the service you get now, but it could help other children and families with the same problems later if we find we need to make our service better.

What if you have any questions?

You can ask us questions any time when you are here or later. You can also talk to your mom or dad or anyone else if you have questions about this study.

Do you have to do this?

No you do not have to do this if you do not want to. Nobody will be mad at you if you say you do not want to be in the study or if you want to ask more questions. You can also change your mind later. The Team will still do the same assessment and give suggestions to you and your family even if you do not want your information to be used in the study.

I want to participate in this study.

Child's Name (Print): _____ Child's Signature: _____
Date:_____

Person Obtaining Assent:_____
Signature:_____
Date:_____

APPENDIX F

FORM A

Western Education

Faculty of Education
Graduate Programs & Research Office

Print Form

Reset Form

APPROVAL OF M.Ed. THESIS PROPOSAL

If the proposed research does not involve human subjects or the direct use of their written records, video-tapes, recordings, tests, etc., this signature form, along with ONE copy of the research proposal should be delivered directly to the Graduate Programs & Research Office for final approval.	If the proposed research involves human subjects, this signature form, along with ONE copy of the research proposal and Ethical Review Form signature pages (Section 1.1 to 1.7) must be submitted to the Graduate Programs & Research Office for final approval.

IT IS THE STUDENT'S RESPONSIBILITY TO PROVIDE A COPY OF THE RESEARCH PROPOSAL (INCLUDING REVISIONS) TO THE THESIS SUPERVISOR AND ALL MEMBERS OF THE ADVISORY COMMITTEE.

Student's Name: Julia Rick **Student #:** _____

Field of Study: Counselling Psychology

Title of Thesis: Profiling children and youth with problematic sexual behaviours

Name of Thesis Supervisor: Dr. Alan Leschied

Name of Thesis Advisory Committee Member: Dr. Susan Rodger

DOES THIS RESEARCH INVOLVE THE USE OF HUMAN SUBJECTS: (•) Yes ( ) No

APPROVAL SIGNATURES:

Graduate Student : _____ **Date:** _____

Thesis Supervisor: _____ **Date:** _____

Advisory Committee: _____ **Date:** _____

Ethical Review Clearance: _____ **Date:** _____

Ethical Review Number: _____

Associate Dean
Graduate Programs & Research: _____ **Date:** _____

A STUDENT MAY PROCEED WITH RESEARCH WHEN A COPY OF THIS FORM CONTAINING ALL APPROVAL SIGNATURES HAS BEEN RECEIVED.

A copy of this proposal may be made public and kept on a two-hour reserve in the Faculty of Education Library.

Version Date: January 2010

VITA

Name:	Julia M. L. Rick	
Post-secondary Education and Degrees	University of Western Ontario London, Ontario, Canada M.Ed., Counselling Psychology	2010-2012
	University of Western Ontario London, Ontario, Canada Honours B.A., Psychology	2006-2008
	University of Western Ontario London, Ontario, Canada B.ACS., Business	2001-2005
Honours and Awards:	Western Graduate Research Scholarship (WGRS)	2010-2012
	Centre of Excellence Undergraduate Scholarship Award	2008
	Undergraduate Scholarship Research Award (Presenter: Child and Parent Resource Institute)	2008
	Queen's Venturer Award (Presenter: Lieutenant-Governor, Hilary M. Weston)	2000
Related Work Experience:	Psychology Practicum Student Centre for Addiction and Mental Health	2011-2012
	Trauma Counsellor and Group Co-Facilitator Durham Rape Crisis Centre	2011-2012
	Distress Line Counsellor London and District Distress Centre	2008-2009
	Youth Mentor and Group Co-Facilitator Boys' and Girls' Club of London, Ontario	2008-2009
Research Experience:	Research Assistant Child and Parent Resource Institute	2008-2011
	Research Assistant Centre for Addiction and Mental Health	2010
	Research Assistant University of Western Ontario	2008