

Children with Sexual Behaviour Problems: Descriptive Statistics and Adverse Childhood

Experiences

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Abstract

The current study aimed to provide WellStop, an organisation that seeks to reduce sexual behaviours in children, with information about their clients. The casefile data used in this study came from the five sites WellStop have in the lower half of the North Island of New Zealand. The study was interested in identifying the childhood experiences and sexual behaviours of children referred to specialist community based programmes. It was primarily focused on 1) negative childhood experiences, 2) types of sexualised behaviours (as well as any differences between sites on these factors) and 3) the relationship between childhood experiences and the number of sexualised behaviour. The results showed significant differences between New Plymouth and Gisborne, Napier and Palmerston North on childhood experiences. Furthermore, a significant positive relationship was found between negative childhood experiences and sexual behaviours. Descriptive statistics are presented, and breaks down types of sexual behaviours and childhood experiences across the sites. The results suggest that negative childhood experiences should be a focus in treatment. It may also be useful to include a procedure that screens childhood experiences in referrals to WellStop.

Introduction

The literature focusing on Sexual Behaviour Problems (SBP) generally investigates adult or adolescent populations. Research around children with these problems is less common and consequently they are an understudied group (Chaffin et al., 2006). As such, more research is needed in order to gain a better understanding of this population. The current study aims to provide further knowledge about children with SBP and some of their developmental experiences that may be playing a role in the manifestation of sexual behaviours. As New Zealand does offer specialist treatment for children with SBP, it is important to undertake research into this area in order to inform best practice.

Definitions

The key defining features of SBP include that they are committed by a child younger than 12 years and involve some sexual features that are inappropriate for the age of the child (Letourneau, Schoewald & Sheidow, 2004). These behaviours may be coercive in nature, interfere with developmental processes, and are harmful. This harm can be physical, emotional or psychological and can be committed on the self (e.g., masturbation) or on others (Letourneau et al., 2004). Although these behaviours are sexual in nature the intentions of these behaviours may not be; they may reflect curiosity, anxiety or attention-seeking behaviours (Chaffin et al., 2006). In order to decide if the sexual behaviour is inappropriate it needs to be rare in the culture the child lives in and persist after efforts by caregivers to stop the behaviour (Chaffin et al., 2006). As mentioned previously, the age of the child needs to be taken into consideration, as inappropriate behaviours for a 10-year-old are different from those for a 4-year-old (Chaffin et al., 2006). For example, preschoolers touching each other's private areas is considered normal but if this behaviour was done by ten-year-olds it would be inappropriate (Miragoli, Camisasca & Di Blasio, 2017).

Language

The language used to describe SBP in children demands important consideration as using the wrong language can create stigma for children. Sexualised behaviours in children are classified on a continuum from normal to violent. The first point on the continuum highlights that there is a *normal* range of sexual behaviours which vary according to the age of the child (Chaffin et al., 2006). These may include behaviours such as self-stimulation in a private setting. Next in the continuum of SBP is *inappropriate behaviours* (Hackett, 2011). Inappropriate behaviours occur only once and are often consensual when between peers, however the context that the behaviours are occurring in are of concern. For example, if a child is masturbating in public the context it is inappropriate, whereas if this behaviour was in private it would be considered a normal behaviour. The next is *problematic*, behaviours at this stage of the continuum are age inappropriate and may not be reciprocal. The following is *abusive*, these include behaviours that are coercive, intrusive and lack consent from the victim (Hackett, 2011). And the last on the continuum is *violent*, these behaviours involve a level of physical aggression and their actions may be arousing for the person carrying out these behaviours.

The current study is using the term 'children with SBP' as this covers the range on the continuum that includes inappropriate, problematic, abusive and violent behaviours (Grossi, Lee, Schuler, Ryan & Prentky, 2016; Hackett, 2011). This term is also beneficial as it does not label the individual in the way terms such as 'sex offender' does (Okami, 1992; Johnson, 2000). Further, the term 'children with SBP' does not make an attempt to pathologise the behaviour or reflect public disapproval of the behaviour. Rather, it labels the behaviour separate to the child and is not classed as an identifying feature of their personality (Okami, 1992). As such, this avoids creating stigma with the language used to describe children with SBP.

Prevalence

The prevalence of SBP in children is hard to find as they are an understudied population (McKibbin, Humphreys & Hamilton, 2017). The majority of the research has been based on populations involved with intervention, and there are limited studies on the prevalence rates in the general population (McKibbin et al., 2017; Szanto, Lyons & Kisiel, 2012). However, there is research on the rates of adolescents with SBP. One study considered a group of adolescents from the general population and suggested that around 9% presented with SBP (Ybarra & Mitchell, 2013). Interestingly however, when looking at a group of sexually abused youth it was found that over half had been abused by another child or young person (Radford, Corral, Bassett, Howat & Collishaw, 2011). Moreover, the rate varies across countries, though this is influenced by variability on the definition of SBP used (McKibbin, 2017). Another piece of research looked at SPB in a school context, the major findings showed males display more sexual behaviours than girls and younger children display more sexual behaviours than older children (Miragoli, Camisasca & Di Blasio, 2017). The authors did not note the prevalence of these sexual behaviours in their population of children. Consequently, the prevalence rates in the general population is difficult to identify but may be somewhere around the 10% mark, though this may be a conservative number.

Differences between children and adolescents

As noted above, in the context of this study children with SBP refers to those under the age of 12 years. There are key developmental differences between children and adolescents which may impact their sexual behaviours (Rich, 2006; Chaffin et al., 2006). One example of a difference proposed by Rich (2006) is that children have a different understanding of sex than adolescents. This is important to note as often a child's sexual behaviour is out of curiosity or a lack of understanding as opposed to adolescents who may have more harmful intent behind it (Rich, 2006). Another difference between adolescents and children in the presentation of

SBP pertains to gender (Chaffin et al., 2006). Research on children with SBP suggests that the ratios of males to females is more evenly distributed than that which is found in adolescents with SBP. Although this points to differences between adolescents and children with SBP, one article proposes that adolescents with SBP are more similar to children with SBP than they are with adolescents committing sex offences (Letourneau, Schoewald & Sheidow, 2004). It is important to note the differences between sexual offending and sexual behaviour. Sexual behaviours are behaviours that are sexual in nature but do not result in a conviction. Whereas sexual offending is where the sexual behaviour results in a conviction. As such, where the research looking at children with sexual behaviour is limited, literature based on adolescents with SBP rather than the literature on juvenile sexual offending will be used.

Developmental experiences

Developmental experiences in childhood are often associated with a range of outcomes in later life. Often protective factors, e.g., a positive attachment style, are associated with better outcomes in life (Garofalo & Bogaerts, 2017; Forsman, Johansson, Santtila, Sandnabba & Langstrom, 2015). Having a positive attachment with a parent or caregiver is associated with better mental health and less offending in future life (Garofalo & Bogaerts, 2017). Conversely, aversive childhood events have been associated with a range of negative outcomes in life (Szanto et al, 2012; Perez, Jennings & Baglivio, 2018). Szanto et al. (2012) looked at the relationship between early childhood trauma and the development of SBP in children. They found that multiple trauma experiences in childhood were related to the development of SBP. The authors suggest there are key traumas that appear to have a stronger relationship with the development of SBP (Szanto et al., 2012). These are exposure to violence as well as a history of sexual abuse. From these results it is clear that negative childhood experiences may play a role in the development of SBP.

Research into the area of childhood experiences has established a list of these negative events in childhood and has termed them Adverse Childhood Experiences (ACEs) (Felitti, 1998; Cale & Lussier, 2017). Some of the 10 experiences in the ACEs literature include experiencing physical, sexual or emotional abuse. The presence of numerous ACEs has been routinely associated with negative outcomes in later life, including the development of SBP (Cale & Lussier, 2017). As such, the current report will use the ACEs literature as a guideline for recording childhood experiences.

There are other experiences in a child's background that is not explicitly stated in the ACEs literature that may be relevant to the presentation of SBP. An example is exposure to sexualised behaviours, this may be through witnessing parents or others engaging in sexual intercourse or through exposure to pornography. One study has found that being exposed to sexualised behaviours can result in the presentation of SBP, as well playing a potential role in the maintenance of it (Levesque, Bigras & Pauze, 2012). As such, witnessing sexualised behaviours appears to be a relevant background feature to include in relation to the development of sexual behaviours.

Another background feature that is of interest is parenting styles. One study looked at the characteristics of the parents of youth who had committed sexual acts (Worley, Church, & Clemmons, 2012). The results showed that parental inconsistency in the disciplining of the child were associated with the persistence of sexual behaviours into later life. Although this only explains the maintenance of SBP over time, given that the definition of SBP includes the persistence of the SBP even when asked to stop, it may be possible that parental consistency is an issue. Consequently, the consistency of punishment of children appears to be a relevant childhood experience.

Disruptions in care, characterised by numerous changes in caregivers or placements, appears to have some relationship with behavioural issues in children. One issue with this

finding however, is the direction of this relationship, do the behaviour problems cause disruption in care (i.e. caregivers cannot handle the child) or do disruptions in care cause the behaviour problems (Jakobsen, 2013). Although this is an issue that needs considering disruptions in care seem to have a relationship with behaviour problems in some way. Therefore, the inclusion of disruptions in care seems to be warranted.

Aims

The current research aims to provide a research base for WellStop, this is an organisation that provides assessment and treatment for children, adolescents, and adults with SBP. More specifically, the organisation would like to gather some descriptive statistics about the children coming into the agency, both in terms of their background, and the sexual behaviours they present with. WellStop is also interested in whether there are differences in the ways clients present across their different branches. The current study hypothesises that children who report more ACEs will be likely to have more SBPs. Moreover, the current study also hypothesises that there will be little differences between the sites of WellStop.

Method

Participants

The current study used the historical data of child clients from WellStop that were referred between June 2016 and June 2017. The total number of child referrals over this period were 204, however many of these were excluded for various reasons. The first reason for exclusion was if the clients had been referred but had not had any assessments completed ($n = 72$). The next reason for exclusion was specific to the Palmerston North site ($n = 56$). Their list of referrals included referrals to the part of their service which deals with trauma. Therefore, these clients were excluded as they had no sexual behaviours. Similarly, some clients were excluded if they had been referred by ACC and did not present with sexual behaviours ($n = 5$). Other exclusions were less common ($n = 6$) these included clients having incomplete

assessments, missing files or clients being too old. Although, some of the clients included were over age twelve years, at the time of their referral and assessments they were 12 years old so are included in our sample for this reason.

After all these exclusions, there were 66 child clients left. The participants consisted of 22 females and 44 males. The mean ages are presented in table 2 alongside the age range and other demographic details.

Materials

Data were collected from historical casefiles at WellStop. These were analysed and information was put into three categories. Demographics were collected for each participant including age, gender and ethnicity. The second category included data relating to ACEs. And the last category was the sexual behaviours displayed by the children as they were reported in the files.

In order to create a list of negative childhood experiences, the current study drew primarily from the ACEs checklist to establish relevant categories (Finkelhor, Shattuck, Turner & Hamber, 2015). The ACEs consists of ten items that aim to measure early childhood events (Finkelhor et al., 2015). The items were namely, physical abuse, emotional abuse, sexual abuse, emotional and physical neglect, absence of parent (through separation or death), mental illness in the home, substance use in the home, incarcerated parent(s), and exposure to domestic violence. However, neglect was often not broken down into emotional and physical neglect in the assessment reports. Consequently, these two categories were merged together into a single category of neglect as this was commonly mentioned by assessors. Additional categories were added to the list of ACEs that were specific to the area of SBP. These were exposure to sexualised behaviour, inconsistent parenting, disruptions in placement, sexual behaviours done to them by other children. As such, this updated list is going to be referred to as ACEs Plus to acknowledge the extra childhood experiences included.

The SBP that were reported to have been displayed by the sample were broken down into separate categories in order to identify the number of sexual behaviours per child. Table 1 breaks down these behaviours and how they are defined in this context. The *other* item was included for SBP that fell outside the scope of any other items and/or was not common across the sample.

Table 1.

Definitions of Sexual Behaviour Items

Sexual Behaviour	Definition
Boundary	Children who stand too close to others or do not understand personal boundaries.
Language	Children who use language that shows knowledge of sex above that which is age appropriate.
Touching over clothes (Adult)	Children who touch adults over clothes.
Touching over clothes (Children)	Children who touch other children over clothes.
Touching under clothes (Adult)	Children who touch adults under clothes.
Touching under clothes (Children)	Children who touch other children under clothes.
Exposure	Children who expose themselves to others inappropriately.
Peeping	Children who are caught peeping at adults or other children who are naked.
Asking others to expose themselves	Asking others to expose themselves.
Masturbation	Children who masturbate excessively, in public, or more than is age appropriate.
Inappropriate media use	Children who are sending inappropriate pictures of themselves or others.
Internet/Pornography	Children who used or had seen pornography.
Humping	Children who engaged in a humping action with others or toys.

Other	Any sexual behaviour that does not fit into these categories.
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A data file was created in Excel and scores on each item were recorded. If the item was mentioned in the assessment file of a participant it was coded as being present, if it was not mentioned it was coded as not present. All identifying features of participants were removed or not entered in the data set.

Moreover, site was also coded for, in order to see if there were differences in the presentation of the children across different sites. As such, the five sites of WellStop are located in Wellington, Gisborne, Napier, New Plymouth, and Palmerston North. The site each participant was from was recorded.

Results

The descriptive statistics of the sample are featured in Table 2. These have been broken down by region and have a cumulative total of all the regions at the end. One thing to note here is the ratio of males to females. Moreover, the population of Maori in the current study are over-represented when compared to the national population.

Table 2.

Descriptive statistics

Factor	Wellington	Gisborne	Napier	New Plymouth	Palmerston North	Total
<i>Age</i>						
<i>(Years)</i>						
Mean	8	9.8	8.2	9	8.8	8.4
<i>SD</i>	2.5	3.5	2.4	2.8	2.1	2.5
Min	4	4	5	6	5	4
Max	13	12	12	12	13	13
<i>Gender (n)</i>						
Male	16	2	9	4	13	44
Female	7	3	9	1	2	22
<i>Ethnicity</i>						
<i>(n)</i>						
NZE	15	4	10	4	5	38
Maori	7	1	6	1	9	24
Other	1	0	2	0	1	4
<i>n</i>	23	5	18	5	15	66

ACEs Plus

Figure 1 shows the total mean scores of the regions on the ACEs Plus. The combined total mean score of all regions was moderately high ($M = 4.77$, $SD = 2.87$). One thing to note in Figure 1 is the high rates of ACE scores in Gisborne and the low rates in New Plymouth. A

one-way ANOVA* was run to test for the statistical difference between the total mean ACEs Plus scores for the different sites. The results showed a significant effect of ACEs Plus scores on the sites ($F(4, 61) = 5.60, p = .001$). This suggests that there are statistical differences in the mean scores across the sites. However, the Levenes test ($F = 2.84, p = .032$) showed that

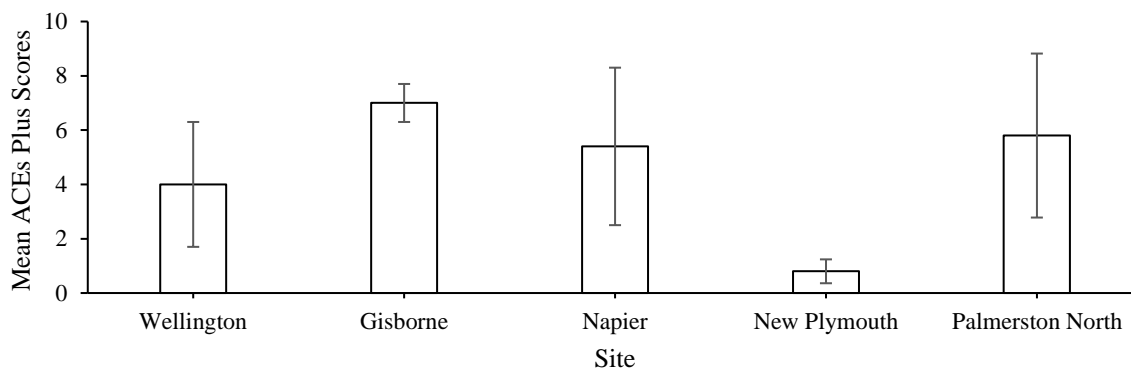


Figure 1. Mean ACEs Plus scores across regions.

the variance of the total mean scores for each site was not homogenous. A post-hoc comparison was computed using the Tukey HSD test and this found that the total mean score for New Plymouth ($M = .80, SD = .45$) was significantly different from the total mean scores of Gisborne ($M = 7.00, SD = .71$), Napier ($M = 5.39, SD = 2.89$), and Palmerston North ($M = 5.87, SD = 3.02$). No other significant differences were found in the post hoc tests. When taken together these results suggest that the total mean ACEs Plus score of New Plymouth is statistically different from that of Gisborne, Napier and Palmerston North. This proposes that New Plymouth has lower ACEs Plus total mean scores than the other sites. No other differences in total mean ACEs Plus scores were found across the sites. However, we should be cautious in interpreting these results as accurate as the group sizes varied greatly, New Plymouth and Gisborne in particular had small sample sizes. Moreover, as the Levene's statistic was significant this may suggest that the variance between the samples were not comparable.

Figure 2 shows the rates of all ACEs Plus scores and breaks down how many people from each sites contributed to the total number of each ACEs Plus item. The most common

*One-way ANOVA met assumptions

ACE was the absence of a parent, this was followed by witnessing domestic violence, mental illness and neglect respectively.

Figure 3 shows the number of ACEs Plus the sample had experienced. Here it is important to note that 95.5% of children had experienced at least one ACE, and the majority (50.9%) had experienced more than three ACEs plus scores.

SBP Scores

The mean scores for the number of SBP displayed by the sample have been split according to site in Figure 4. These were relatively consistent across all the regions. A one-way ANOVA was computed and found that there were no statistical differences between any of the sites. The mean score was relatively high for all the sites ($M = 4.19$, $SD = 1.63$).

Figure 5 shows the rates of SBP for each sexual behaviour across each of the different sites. As the figure shows, the most common sexual behaviours were touching other children under and over clothes followed by language. The least common were asking others to expose themselves and touching adults under clothes.

Figure 6 shows the number of SBP that were reported to have been displayed by the sample. The majority of the sample had more than three sexualized behaviours, and all had at least one. As such, sexualized behaviours were pervasive in the sample

ACEs Plus and SBP

A correlation between ACEs Plus scores and number of sexual behaviours was computed. The results showed a significant moderate positive relationship ($r(65) = 0.362$, $p < 0.01$). This suggests that the more ACEs Plus an individual had experienced, the more sexual behaviours they would display.

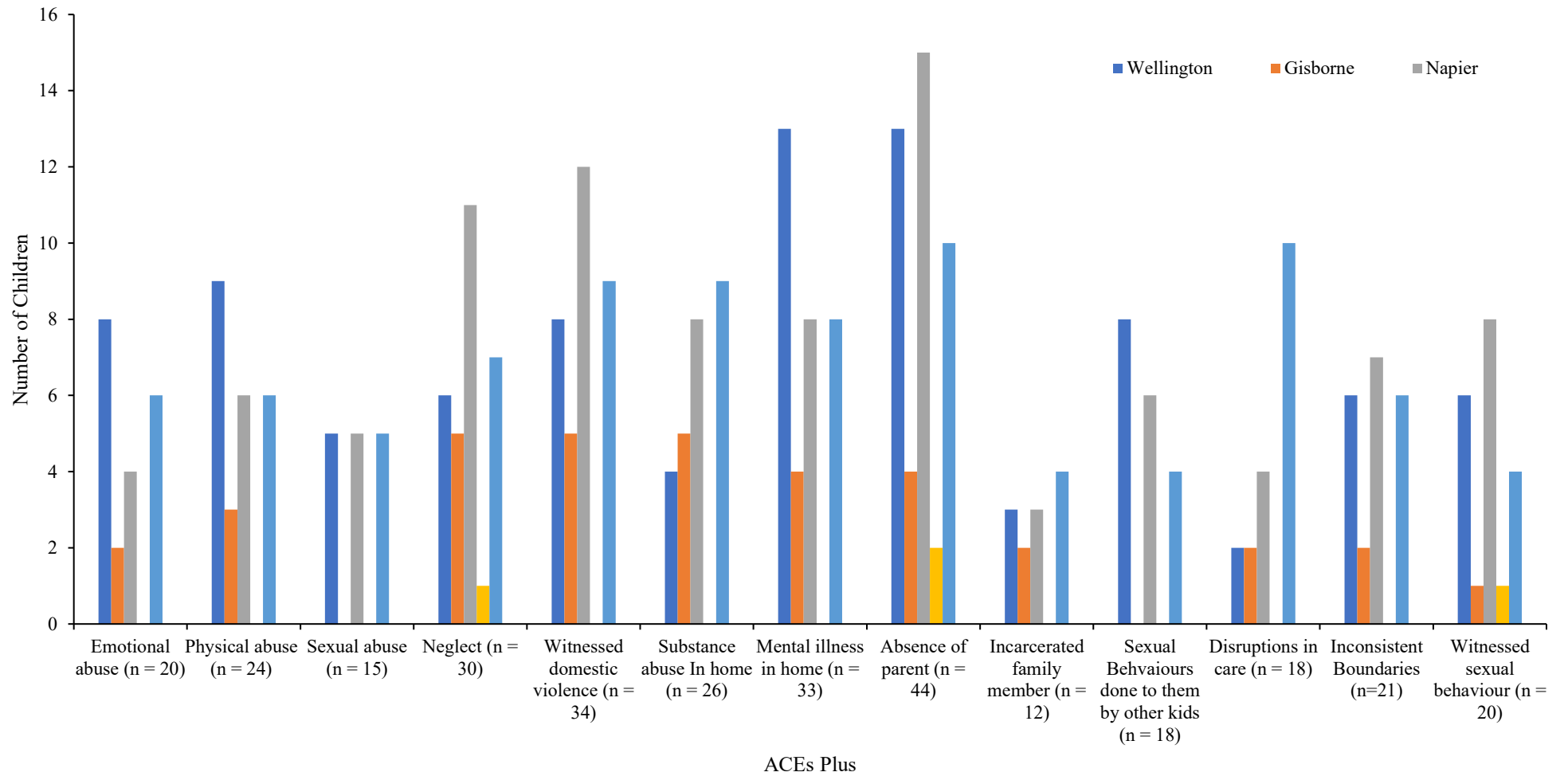


Figure 2. ACEs Plus scores across WellStop sites.

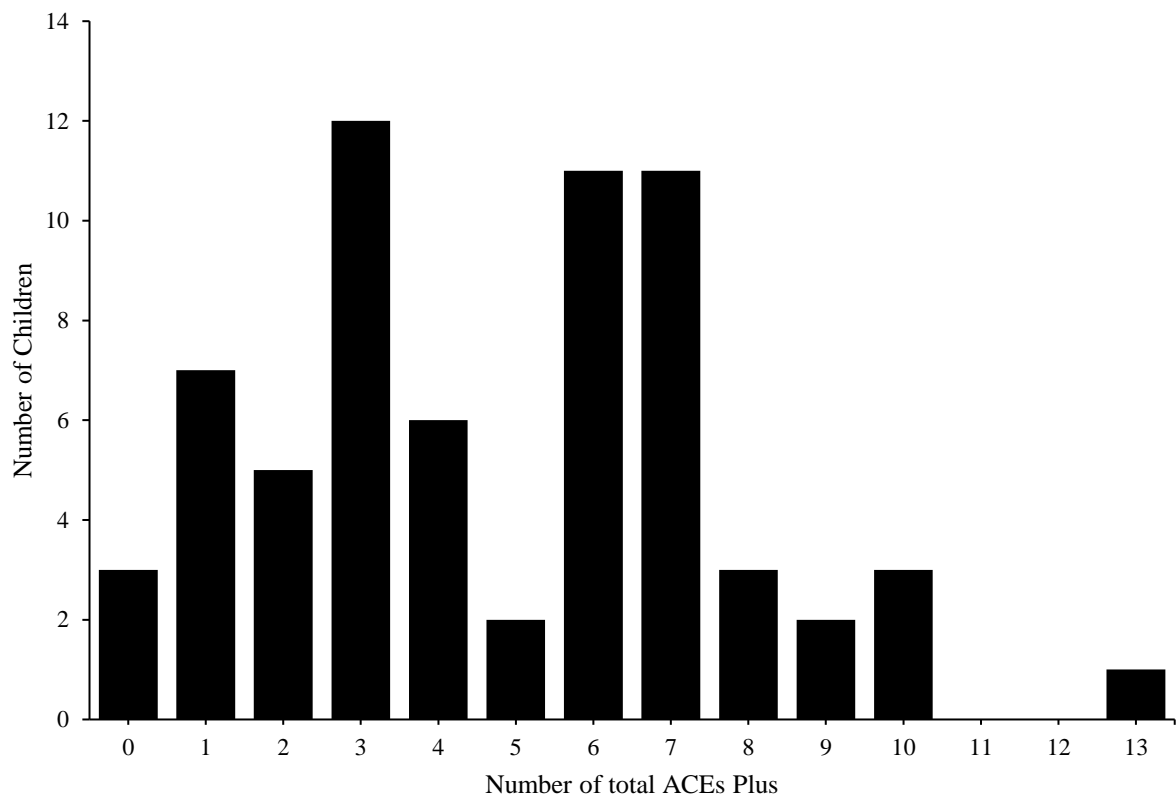


Figure 3. Total ACEs Plus scores per child.

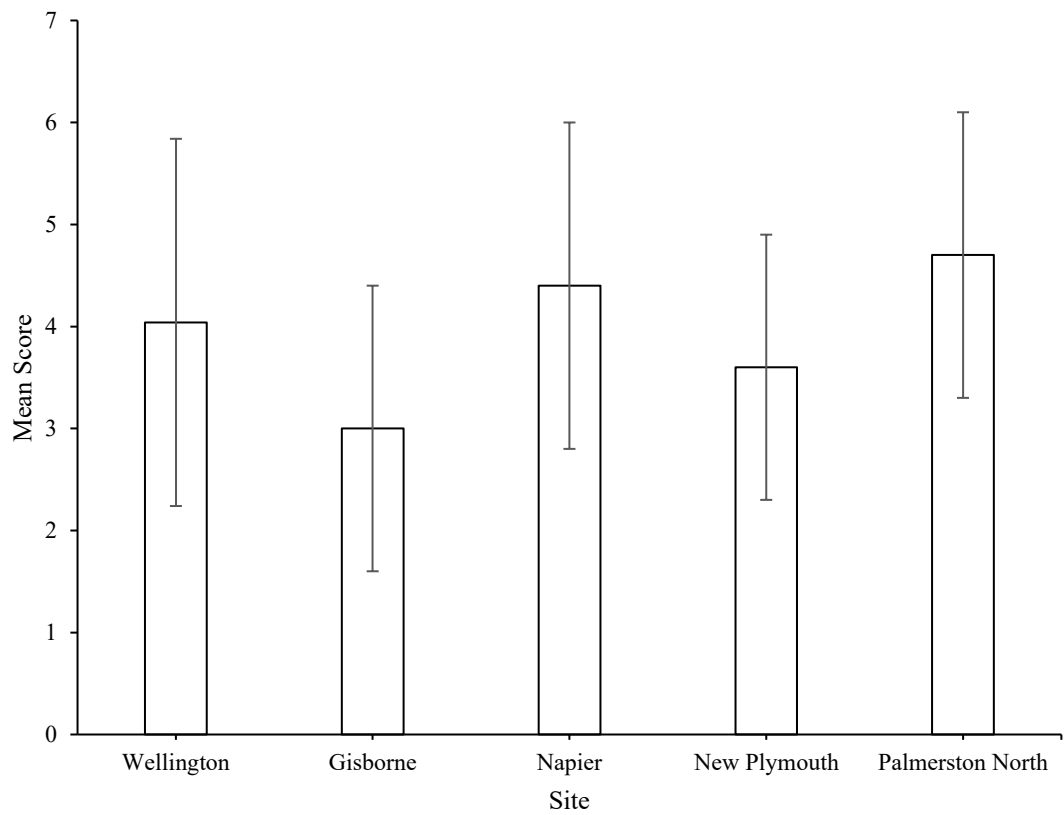


Figure 4. Mean SBP scores for each site.

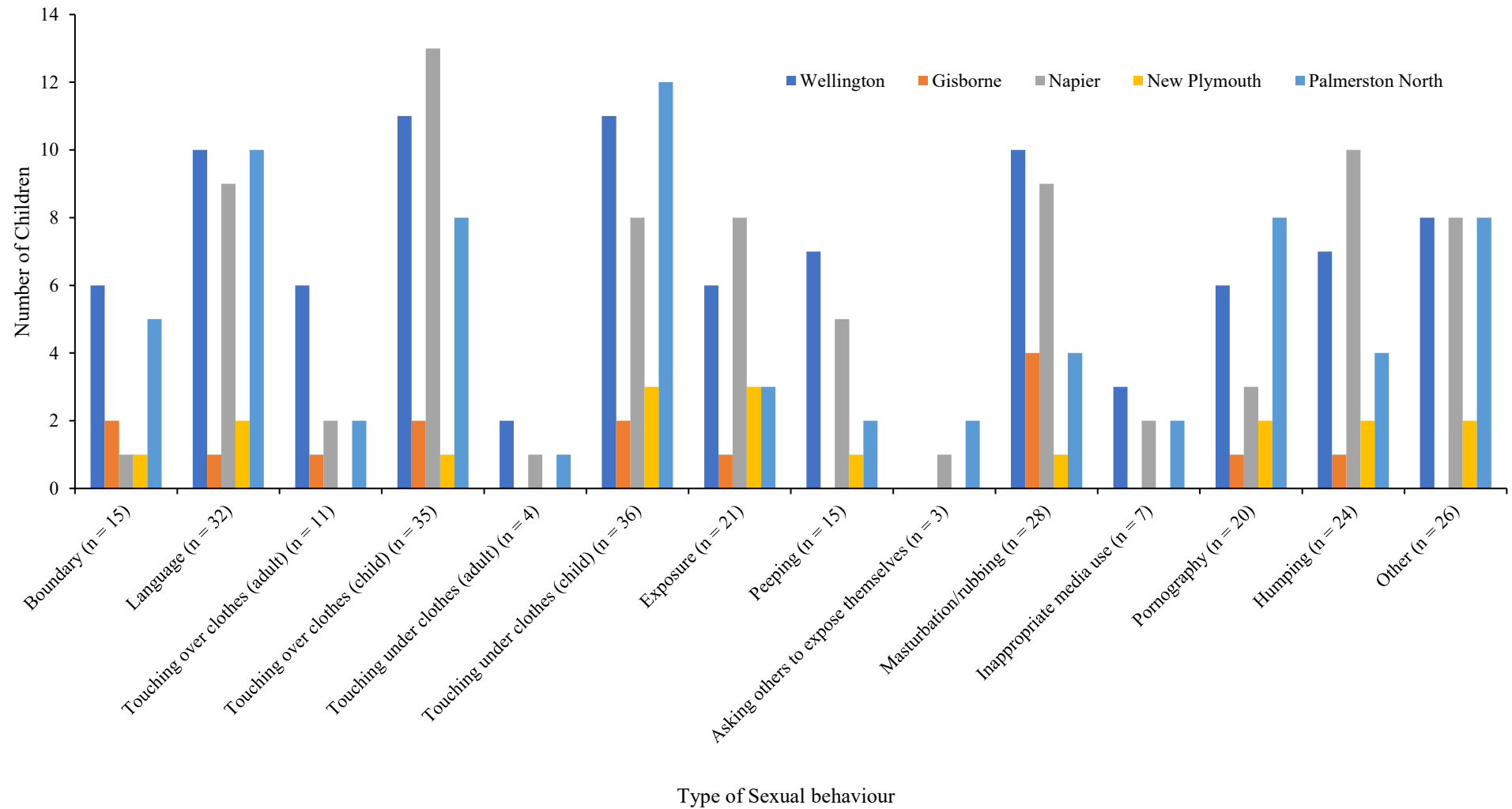


Figure 5. Type of sexual behaviours displayed by children across the sites.

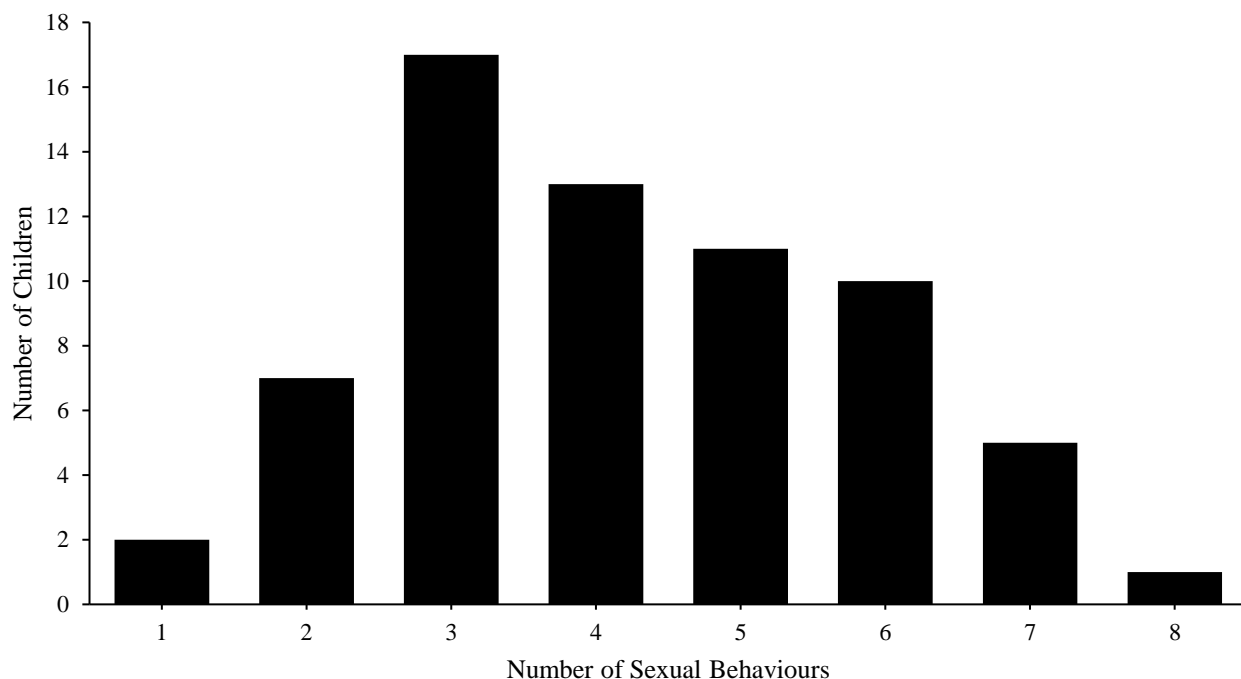


Figure 6. The number of sexual behaviours displayed by sample.

Discussion

The current study aimed to investigate any relationship between ACEs and SBP. Furthermore, differences between WellStop sites on rates of SBP and the number of ACEs Plus were investigated. Consistent with the hypothesis, a positive relationship was found between SBP and ACEs Plus scores, suggesting that the more ACEs an individual has the more sexual behaviours they display. Furthermore, the results showed significant differences between sites on ACEs plus scores. The rates of SBP were not statistically different between the sites.

The mean ACEs Plus scores for all participants suggests that the majority of individuals have had a range of aversive experiences in their childhood. The most common ACE was the absence of a parent, followed by witnessing domestic violence and mental illness. This is consistent with for previous overseas literature (Szanto et al., 2012). Aligned with Szanto et al. (2012), exposure to violence was high amongst our participants. Sexual abuse was not as common in our population as it is in the research by Szanto et al., 2012. However, the low rate of sexual abuse in the current study supports a similar finding by Silovsky and Niec (2002).

They found that only 11% of their sample had experienced sexual abuse. This suggests that, overall, our results are consistent with most of the previous research of childhood experiences children with SBP.

The current study's findings of the rates of different types of sexual behaviour are similar to past literature. For example, Miragoli and colleagues (2017) looked at sexual behaviours in a general population and found that one of the most common behaviour was touching other children and language; this was consistent with the results in the current study. However, peeping behaviour was common in Miragoli and colleagues (2017) sample, and in the current study this behaviour was less common. Pornography use was common in the current study, consistent with research by Wright, Tokunga and Kraus (2016) who found that pornography use was associated with sexually aggressive behaviours. As such, the rates and presentation of types of sexual behaviours displayed in the current study are consistent with previous literature.

The finding that ACEs Plus are related to sexual behaviours supports past research (Szanto et al., 2012; Silovsky and Niec, 2002). Szanto and colleagues (2012) found that adverse child experiences were related to the development of sexual behaviours in children and adolescents. The findings in the current study align with this as they showed that the higher the ACEs Plus score a person had the more likely they were to also have engaged in a higher number of sexual behaviours.

The results of the current study have many implications. Firstly, the high number of ACEs suggests that children referred to WellStop have a high number of negative experiences in childhood that may be impacting on their sexualised behaviours. Moreover, these experiences may impact on their ability to engage in treatment. Therefore, it is recommended that these ACEs Plus categories should be targeted in treatment. The inclusion of a screen for childhood experiences that include all categories in the ACEs Plus would be valuable. This

would be important as it would help to focus intervention. It also may help in ascertaining the level of intervention that is needed, given the relationship found between SBP and ACEs Plus scores (e.g., those with more ACEs plus scores also have more sexual behaviours).

Given the statistical differences found between sites, this suggests that New Plymouth should be treated as a separate distinct category from Napier, Gisborne and Palmerston North. This would be relevant for future research in that New Plymouth should not be lumped together as there may be differences in the presentation of clients their due to statistical differences in mean scores. However, this finding may have been influenced by the small sample sizes in New Plymouth and Gisborne. As such, we should be cautious in taking this finding at face value.

There are several methodological limitations to the research that are important to consider. The first is that, due to the data being drawn from casefiles, it is only possible to code what was on the file. This is a problem because if a childhood experience, such as physical abuse, is not mentioned in the file it may not be mentioned because it was not experienced by the child or because the clinician did not ask about it. As such, this is a limitation as the accuracy of these casefiles cannot be guaranteed, as it was not possible to check up on these factors with the participants. This also ties into the sexual behaviours displayed by the clients as the behaviours recorded on the assessments were the behaviours that a client was referred for. However, behaviours that occurred during the treatment process were not recorded. As such, the rates of sexual behaviours may be an underestimate of the true rates.

The second limitation to note is that the ACEs scale was not consistently completed by the clients at WellStop. This ties into the first limitation in that some had filled out an ACEs checklist on referral sheets and some had not. On top of this, information provided by clients in the ACEs often proved to be inconsistent with the information obtained by clinicians during the assessment. This may be due to the lack of understanding of the concepts in the ACEs by

the people completely them (e.g., parents and caregivers). As such, ACEs could be more accurately measured if it were possible to ask clients or clinicians about them.

The third limitation is the small sample sizes in Gisborne and New Plymouth. Both of these regions only had 5 participants each. A larger sample size would have given more statistical power and would have given more certain results in this study. Also given that the Levenes statistic was significant we cannot rule out type 1 error, that is, that the sample reflects a false positive. Further research utilising a larger sample size is needed to be certain of results from the current study. Therefore, future research should aim to include a larger sample size in order to test for significant differences across sites. This would establish the validity of our results if statistical differences were found. Furthermore, the study should use active participants as opposed to casefiles, this would eliminate some of the limitations to the current study such as not being able to ask about specific ACEs.

The current study aimed to provide WellStop with information about their clients aged under 12 years. This involved gathering information about the negative childhood experiences and the types of sexual behaviours their clients presented with. Further, though differences were found between the sites in the ACEs Plus for clients these may not be accurate given small sample sizes. The results also showed that the more ACEs Plus a client has the more sexual behaviours that person is likely to have. As such, it is recommended that these ACEs items should be addressed in treatment.

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