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Clinical Report The Evaluation of Sexual Behaviors in Children

Nancy D. Kellogg and Committee on Child Abuse and Neglect
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Clinical Report—The Evaluation of Sexual Behaviors in Children

abstract

Most children will engage in sexual behaviors at some time during childhood. These behaviors may be normal but can be confusing and concerning to parents or disruptive or intrusive to others. Knowledge of age-appropriate sexual behaviors that vary with situational and environmental factors can assist the clinician in differentiating normal sexual behaviors from sexual behavior problems. Most situations that involve sexual behaviors in young children do not require child protective services intervention; for behaviors that are age-appropriate and transient, the pediatrician may provide guidance in supervision and monitoring of the behavior. If the behavior is intrusive, hurtful, and/or age-inappropriate, a more comprehensive assessment is warranted. Some children with sexual behavior problems may reside or have resided in homes characterized by inconsistent parenting, violence, abuse, or neglect and may require more immediate intervention and referrals. *Pediatrics* 2009;124:992–998

INTRODUCTION

Sexual behaviors in children range from normal and developmentally appropriate to abusive and violent. Concerned parents often present to the pediatrician's office with questions about whether their child's sexual behavior is normal, whether the behavior indicates that the child has been sexually abused, and how to manage such behavior. Although earlier studies^{1,2} have suggested a strong correlation between sexual abuse and sexual behavior problems in children, more recent studies^{3,4} have broadened this perspective, recognizing a number of additional stressors, family characteristics, and environmental factors that are associated with intrusive and frequent sexual behaviors. Clinicians must first distinguish age-appropriate and normal sexual behaviors from behaviors that are developmentally inappropriate and/or abusive (sexual behavior problems). Children with sexual behavior problems require further assessment and more specialized treatment approaches.

Sexual behaviors are common in children. More than 50% of children will engage in some type of sexual behavior before their 13th birthday.^{5,6} In 1 retrospective study of 339 child welfare and mental health professionals in which participants were asked about their own experiences before 13 years of age, 73% recalled engaging in sexual behaviors with other children, 34% recalled showing their genitals to another child, 16% recalled simulating intercourse with another child, and 5% recalled inserting an object in the vagina or rectum of another

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KEY WORDS

sexual behaviors in children, child sexual abuse

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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child.⁷ Another study⁹ of female undergraduates reported that 26% recalled exposing themselves, 17% recalled unclothed genital touching, and 4% recalled oral-genital contact during childhood. Frequencies of childhood sexual behaviors retrospectively reported by adults may differ from frequencies contemporaneously reported by parents; recollection differences through time, personal acceptance of sexual behaviors as normal, and the extent to which the behavior is covert may explain some of the discrepant results. Mothers who are more educated and who acknowledge that sexual behaviors in children can be normal tend to report more sexual behaviors in their children when compared with mothers with fewer years of education and less acceptance of these behaviors.⁹ It is not clear whether the mother's acceptance of certain sexual behaviors as normal affects her observation of such behavior or her response to such behavior; a mother who is less accepting of sexual behaviors may be less likely to report such behavior or may modify her child's overt sexual behavior with disapproval or negative feedback.

Whether a child is brought to the pediatrician's office with a complaint of

sexual behaviors depends in part on the parents' knowledge and attitude about the behavior. Several additional factors modify the extent and nature of the child's sexual behavior: age of the child, developmental stage of the child, family environment, and parental behavior and response to the child. Some children may display sexual behaviors that are common and age-appropriate but that can become problematic and require intervention if the frequency is such that the behavior is disruptive to others.

DIFFERENTIATING NORMAL SEXUAL BEHAVIORS FROM SEXUAL BEHAVIOR PROBLEMS

Differentiating between normal and problem sexual behaviors is a critical role for the pediatrician (Table 1) and may, at times, require more decisive therapeutic evaluation and intervention by a mental health professional. However, normal sexual behavior and sexual behavior problems are not always clearly dichotomous, and distinguishing victim from perpetrator is not always unambiguous, especially when both are children. All children involved, however, do require assistance and guidance from health care professionals as well as parents and schools.

Different terms have been used to characterize sexual or "sexualized" behavior in children. Behavior such as sexualized play may be within a range of normal development among social peers, especially at various critical stages of growth and development, and may only require adult guidance and redirection. On the other hand, sexual behavior problems are behaviors that are developmentally inappropriate, intrusive, or abusive; an alternative, less precise term is "sexual acting out." "Sexually reactive youth" is a more descriptive and less inflammatory term than "youth sex offenders" in describing children and adolescents with sexual behavior problems as a result of inappropriate sexual experiences that include sexual abuse, exposure to sexualized material, and/or witnessing sexual activity by others.

Types of Sexual Behaviors

In a prospective study of children aged 2 to 5 years without a history of abuse (determined by parental screening), common sexual behaviors reported by caregivers include touching their genitals at home and in public, masturbating, showing their genitals to others, standing too close, and trying to look at nude people.⁹ These behaviors do

TABLE 1 Examples of Sexual Behaviors in Children 2 to 6 Years of Age

Normal, Common Behaviors	Less Common Normal Behaviors ^a	Uncommon Behaviors in Normal Children ^b	Rarely Normal ^c
<ul style="list-style-type: none"> ● Touching/masturbating genitals in public/private ● Viewing/touching peer or new sibling genitals ● Showing genitals to peers 	<ul style="list-style-type: none"> ● Rubbing body against others ● Trying to insert tongue in mouth while kissing ● Touching peer/adult genitals 	<ul style="list-style-type: none"> ● Asking peer/adult to engage in specific sexual act(s) ● Inserting objects into genitals ● Explicitly imitating intercourse ● Touching animal genitals 	<ul style="list-style-type: none"> ● Any sexual behaviors that involve children who are 4 or more years apart ● A variety of sexual behaviors displayed on a daily basis ● Sexual behavior that results in emotional distress or physical pain ● Sexual behaviors associated with other physically aggressive behavior ● Sexual behaviors that involve coercion
<ul style="list-style-type: none"> ● Standing/sitting too close ● Trying to view peer/adult nudity 	<ul style="list-style-type: none"> ● Crude mimicking of movements associated with sexual acts ● Sexual behaviors that are occasionally, but persistently, disruptive to others ● Behaviors are transient and moderately responsive to distraction 	<ul style="list-style-type: none"> ● Sexual behaviors that are frequently disruptive to others ● Behaviors are persistent and resistant to parental distraction 	<ul style="list-style-type: none"> ● Behaviors are persistent and child becomes angry if distracted
<ul style="list-style-type: none"> ● Behaviors are transient, few, and distractable 			

^a Assessment of situational factors (family nudity, child care, new sibling, etc) contributing to behavior is recommended.

^b Assessment of situational factors and family characteristics (violence, abuse, neglect) is recommended.

^c Assessment of all family and environmental factors and report to child protective services is recommended.

not vary significantly when boys are compared with girls across all age groups, but they do diminish in both boys and girls after 5 years of age.⁹ Children also engage in sexual behaviors that include other individuals, such as putting their tongue in another's mouth while kissing, rubbing their body against others, and touching children's and adults' genitals, but these behaviors are less common, occurring in fewer than 8% of children 2 to 5 years old.⁹ Fewer than 1.5% exhibit any of the following: putting the mouth on genitals, asking to engage in specific sex acts, imitating intercourse, inserting objects into the vagina or anus, and touching animal genitals.⁹ Such behaviors do not necessarily imply the child has been sexually abused but do merit further assessment. Among normative study samples of children, all 38 sexual behaviors that were studied were observed in at least some of the children,^{10,11} which suggests that there is no single sexual behavior that is a pathognomonic sign of sexual behavior problems or abuse. Normal sexual behaviors usually diminish or become less apparent with redirection and admonishment from the parent, and although such behaviors may result in feelings of embarrassment in the child, feelings of anger, fear, and anxiety are uncommon.⁷

Sexual behaviors that involve children who are developmentally dissimilar or use of coercion and control by 1 child are abusive.¹² Distinct developmental differences occur when children are at least 4 years apart in age or cognitive abilities. Children who are fewer than 4 years apart in age may still engage in abusive sexual contact when 1 child uses physical force or threat of harm against the other child. Abusive behaviors generally occur without other witnesses, and threats to "keep the secret" are common. Abusive sexual

behaviors require immediate and effective intervention.

Children with sexual behavior problems are more likely than children with normal sexual behaviors to have additional internalizing symptoms of depression, anxiety, withdrawal, and externalizing symptoms of aggression, delinquency, and hyperactivity.⁹ This association suggests that some sexual behaviors occur within a continuum of behavioral problems with multifactorial causes.

Another group of children may engage in a greater variety and frequency of sexual behaviors that may be disruptive to others but not necessarily abusive. These behaviors are often noted after a shift in caregiving environments; examples include children placed in foster homes and children who attend child care. Among children who are not suspected victims of abuse, more time spent in child care correlates positively with the number and frequency of observed sexual behaviors.⁹ Child care provides more opportunities for children to interact and explore each other in both sexual and nonsexual ways.

Age

The variety and frequency of sexual behaviors increases in young children up to 5 years of age and then decreases gradually thereafter.⁹ In 1 normative study of 1114 children aged 2 to 12 years, a greater variety and frequency of sexual behaviors were reported by parents of boys and girls aged 2 to 5 years when compared with parents of children aged 6 to 9 and 10 to 12 years.³ These data do not necessarily suggest that sexual behaviors are more common among young children but may reflect differences in observation patterns by parents and display tendencies by young children. Younger children are less aware of breaches in personal space and how their behav-

ior may be construed as sexual or inappropriate. Reactions from others of embarrassment and shame may be misinterpreted as positive responses, prompting the child to persist in the sexual behavior.

FACTORS THAT AFFECT FREQUENCY AND TYPES OF SEXUAL BEHAVIORS

In addition to the child's developmental level and child care environments, other factors influence the frequency and types of sexual behaviors manifested by children. Family sexuality and attitudes toward nudity; exposure to sexual acts or materials; extent of supervision; stressors, including violence, parental absence because of incarceration, death, or illness; and abuse can affect sexual behaviors in children.^{3,7}

Situational Factors

Depending on the child's developmental level, changes in environment and situations may result in an increase in sexual behaviors. Preschool-aged children are naturally inquisitive and undergo periods of enhanced awareness of their environments. Recognition of physiologic gender differences occurs during this time and contributes to inquisitive viewing and touching of other children's genitals. This curiosity-seeking behavior tends to occur within the context of other similar, nonsexual explorations. The birth of a new sibling, suddenly viewing another child or adult in the bathroom, or seeing their mother breastfeed can trigger or amplify children's sexual behaviors. These behaviors tend to be transient and distractible and diminish once the child understands that such behaviors are inappropriate, particularly for public viewing.

Environments in Which Sexuality Is More Open

Children who reside in homes in which there is family nudity, cobathing, or

less privacy when dressing, going to the bathroom, or bathing or in which sexual activities are occurring openly are more likely to openly engage in sexual behaviors.³ Similarly, children from homes with readily accessible pornographic materials or poor supervision of children's access to such materials may use age-inappropriate sexual language and be more prone to engage others in sexual play.

Family Dysfunction and Stress

Sexual behavior problems in children are significantly related to living in homes in which there is disruption because of poor health, criminal activity, or violence. The greater the number of life stresses—including parental battering, death, incarceration, or illness requiring hospitalization; deaths of other family members; and child illness requiring hospitalization—the greater the number and frequency of sexual behaviors observed in children.³ Because child abuse and neglect are more common in homes characterized by violence and criminal activity, children with sexual behavior problems who reside in such homes should be carefully assessed for abuse and neglect. Among children with a history of sexual abuse, 52% indicated that they had lived with an adult batterer during their childhood, and 58% of the child sexual offenders who were in-home males also battered their adult female partner.¹³ As many as 68% of children with sexual behavior problems have witnessed intimate partner violence among their caregivers.⁴ Adult violence in the home is strongly linked to abuse, neglect, and sexual behavior problems in children.

Children With Developmental Disabilities

Children with developmental disabilities may have deficits in several domains that can affect their sexual knowledge and activity. Such children

may encounter challenges with social skills, personal boundaries, impulse control, and understanding what is hurtful or uncomfortable to others, factors that contribute to an increased risk of sexual behavior problems as well as sexual victimization.¹⁴ In evaluating sexual behaviors in disabled children, the clinician should focus on developmental level rather than age when assessing whether behavior is appropriate; an adolescent with the cognitive abilities of a 3-year-old may exhibit self-stimulatory behavior that is consistent with his or her developmental level and inability to determine what behavior is appropriate in public.¹⁵

Abuse and Neglect

Sexual abuse and physical abuse of children are both associated with sexual behavior problems. One meta-analysis of 13 studies involving sexually abused children revealed that 28% had sexual behavior problems,¹⁶ with the highest prevalence occurring in the youngest age groups. Conversely, in 1 study of 201 children 6 to 12 years of age with inappropriate, intrusive, or aggressive sexual behaviors, 48% were sexually abused, 32% had a physical abuse history, 35% had a history of emotional abuse, and 16% had a history of neglect¹⁷; from another study, a 38% sexual abuse validation rate among children with sexual behavior problems was reported.⁴ Manifestation of sexual behavior problems may not immediately follow sexually abusive experiences; in a study of 127 children aged 6 to 12 years with repetitive, diverse, disruptive, or abusive sexual behavior, the latency time between sexual abuse and manifestation of sexual behavior problems was 2.2 to 2.7 years for 6- to 9-year-olds and 3 to 4 years for 10- to 12-year-olds.¹⁸ This period of latency may explain why some children placed out of abusive homes develop sexual behavior problems a

number of months later. Although sexually abused children display more sexual behaviors with greater frequencies than do nonabused children,^{3,19} there is no 1 specific sexual behavior that is indicative of sexual abuse. On average, sexually abused children display sexual behaviors of a variety and frequency that is 2 to 3 times that of children who are not abused or who have psychiatric diagnoses but have not been abused.³ In sexually abused children, sexual behavior problems correlate positively with severity of abuse, number of perpetrators, family member perpetrators, and use of force.^{3,10}

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

Neglect has also been associated with sexual behaviors in children. Lack of appropriate supervision and accessibility to sexually explicit materials may contribute to sexual behaviors seen in children from such homes. In addition, indiscriminate affection-seeking and interpersonal boundary problems have been reported in children who are victims of neglect²⁰; such behaviors are often manifestations of attachment disorders seen in abused or neglected children.

Comorbid Diagnoses

In a clinical sample of 127 children aged 6 to 12 years with sexual behavior

problems, 96% had additional psychiatric diagnoses.¹⁸ The most common diagnosis was conduct disorder (76%), followed by attention-deficit/hyperactivity disorder (40%) and oppositional defiant disorder (27%); most of the children in this sample had more than 1 psychiatric diagnosis.¹⁸ The family environment of children diagnosed with conduct disorders is similar to the family environment of abused children: parents are more likely to administer harsh punishment, dislike their child, be unaware of where their child is, and be emotionally unavailable or unsupportive.²¹ Families of children with severe sexual behavior problems seem to have the same parent-child conflicts as families of children who develop conduct disorders and engage in delinquent behaviors.²²

CLINICAL ASSESSMENT AND TREATMENT

When children present to a clinical setting for an assessment, normal sexual behaviors should be differentiated from behaviors that are frequent, intrusive, or abusive. The Child Sexual Behavior Inventory (available at www.parinc.com/products/product.aspx?Productid=CSBI), developed to evaluate sexual behaviors in children aged 2 to 12 years who have been or may have been sexually abused, may assist clinicians in differentiating normative and atypical sexual behaviors. Because assessments are primarily based on parent history, the clinician should realize that some behaviors that are reported as problematic by the parent may be normal for the child. If sexual behaviors are normal and age-appropriate, parental reassurance and guidance regarding appropriate responses to the behavior may be all that is needed. If sexual behaviors are escalating, frequent, or intrusive, a more comprehensive assessment and treatment may be needed. If child abuse is suspected, or if the parent is ineffective in

limiting the child's access to sexual material in the home, then a referral to child protective services is warranted. In addition, repetitive sexual behaviors between children that have not resolved despite pediatrician and parental guidance and redirection require more urgent intervention and may necessitate a report to child protective services for further investigation. When possible, it is important for pediatricians to maintain a dispassionate clinical response regarding the child perpetrator who may have been a victim of sexual abuse.

When conducting an assessment, clinicians may find that factors contributing to the child's sexual behaviors are multifactorial. A complete, careful assessment of sexual behavior problems will address all possible causes, including sexual abuse. An assessment of sexual behaviors in children may include the following:

1. Developmental considerations: Normal behaviors are seen more frequently in children younger than 6 years and between children of similar age and development. Sexual behavior between children of different development and/or age requires further assessment and possibly reporting to child protective services.
2. Types/frequency of sexual behaviors: Self-stimulation, personal space intrusiveness, interest in language or images of a sexual nature, exhibitionism, and mutual curiosity in peers' genitals are common normal sexual behaviors. Normal behavior tends to be transient and responsive to parental redirection or admonishment. Sexual behavior problems include behaviors that are coercive, persistently intrusive, injurious, and frequent; such behavior usually requires assessment of familial and situational factors and treatment beyond parent redirection.

3. Parent response to the behavior: Children relish attention and may enjoy the parent's discomfort that results from the sexual behaviors they display. Such children may repeat their behavior to elicit the (desired) parent response. If parents divert the child's behavior without emotional response, normal sexual behaviors tend to diminish. Sexual behavior problems may be persistently frequent or may escalate despite an appropriate parental effort to distract the child.

4. Situational factors (siblings, shift in care, nudity, parent education, acceptance of sexual behaviors): New siblings or new caregiving situations with additional children may trigger sexual behaviors; alternatively, new caregivers may become more observant of such behaviors. Children residing in homes in which nudity and/or sexuality are more open and acceptable may demonstrate more sexual behaviors.

5. Access to sexually explicit material or acts: Inappropriate or accidental exposure to sexual acts or materials can result in sexual behaviors. Such behaviors may become problematic if children are exposed to such material persistently or if the material is disturbing. In the latter situation, a careful assessment for abuse and supervisory neglect is appropriate.

In the absence of sex education at home and at school, various forms of media have been a primary source of information for many adolescents.²³ This information is often inaccurate, age-inappropriate, and misleading. In addition, early exposure to sexual content in the media has been linked to earlier onset of sexual intercourse among adolescents.^{24,25}

6. Dysfunctional home environment: Life stresses, especially interparental violence, are strongly associ-

ated with sexual behavior problems in children.

- Abuse/neglect: Children from homes characterized by physical abuse, sexual abuse, or neglect are more likely to have sexual behavior problems than children who are not from such homes. Any child with frequent, persistently intrusive, or abusive sexual behaviors should be assessed for possible abuse and neglect.

PARENTAL GUIDANCE

Reassurance and guidance about normal sexual behaviors can allay questions and concerns that many parents may have. A 3-year-old who begins to masturbate before falling asleep may simply have discovered a self-soothing technique, may have seen the genitals of a new sibling, or may be responding to the stress of returning to his or her mother's house after a weekend visit with his or her father. Appropriate parental responses are key to managing such behaviors.

The assessment of a child with sexual behavior problems may reveal a home

environment characterized by abuse, neglect, or interpersonal violence. Sexual behavior problems in children who remain in such homes will be difficult to treat and manage. If the safety of the child is at risk, child protective services may place the child in alternative care, and sexual behaviors may escalate. Many children with sexual behavior problems will require referral to therapists for further assessment and treatment.

CONCLUSIONS

Many sexual behaviors in children are developmentally normal and transient and occur within a developmental trajectory that includes curiosity-seeking behaviors, testing of interpersonal boundaries, and situational factors that elicit such behaviors. Sexual behaviors that are persistently intrusive, coercive, developmentally abnormal, or abusive are associated with numerous situational and familial factors, including sexual abuse, physical abuse, and neglect. Sexual abuse is a common, but not exclusive, experience among children with sexual behavior problems. Once sexual behavior prob-

lems are identified, a careful assessment of family behaviors and home environment may clarify underlying causes and contributing factors. The clinical approach to children with sexual behaviors may entail a range of responses including tolerance and understanding, parental redirection, further assessment by a mental health professional, and referral to child protective services when abuse or neglect is suspected.

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