# Sexual Behaviors in Children

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# Disclosures

- Dr. Strickler has no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

# Objectives

- Review approaches to supporting healthy sexual development in children
- Review expected sexual behaviors in children
- Review atypical sexual behaviors in children
- Understand how sexual behaviors are interpreted in context of concern for child sexual abuse (CSA)
- Understand how other factors influence sexual behavior

# Promoting Healthy Sexual Development in Children

- Use correct names for body parts
- Support children in talking about their bodies without shame
- Provide developmentally appropriate and accurate sexual education
- Support age-appropriate personal privacy
- Support body autonomy and ability to say no to undesired touch

# How Sexual Behaviors Influence Presentation to medical care

- CSA may present to clinical setting in a variety of ways, including behavior changes prompting concerns for CSA
- No single behavior is absolutely associated with CSA
- There are associations with certain sexual behaviors and CSA

# Common Presenting Complaints

- Younger Children
  - Masturbation
  - Resistance to diaper changes
  - Toileting Regression
  - Sleep regression
- Older Children
  - Poor Academic Performance/truancy
  - Emotional Lability
  - Sleep Disturbance
  - Appetite Changes
  - Self-harm/Suicidal Ideation

# Behaviors Associated with Normal Sexual Development

| AGE | NORMAL BEHAVIOR |
|---|---|
| Infancy | Oral gratification, penile erections with bladder and bowel distention, genital self-stimulation in both genders by 18 months. |
| 2-3 years | Gender identification, enjoy displaying nude body. |
| 3-6 years | Display sexual behavior and understand gender differences; masturbation is common. Like to touch bodies, may include genitals and breasts of parents. Child identifies with parent of same sex. |
| 6-7 years | Still interested in sexuality, but overt behaviors are diminished. Remain curious about sex; use "dirty" words but are more modest than younger children. Learn from peers. |
| Puberty/adolescence | Display fewer family-related sexual behaviors and more interest in peers. |

# Sexual Behaviors

# Age 2-6: common/normal sexual behaviors

- MASTURBATION
- Viewing or touching a peer or siblings genitals
- Showing genitals to others
- Standing/sitting too close
- Trying to view others naked

# Age 2-6: Less common (but normal) sexual behaviors

- Kissing
- Rubbing body against others
- Touching other’s genitals
- Inserts an object into genitals or rectum for curiosity or exploration

# Age 2-6: concerning sexual behaviors

- Imitating intercourse
- Sexual behaviors that involve force or coercion
- Sexual behaviors between children that are more than 4 years apart in age
- Sexual behaviors that cause physical pain or emotional distress, that are obsessive, or that result in anger/aggression when redirection is attempted

# Age 6-9: common/normal sexual behaviors

- MASTURBATION
- Asks about genitals, intercourse and babies
- Plays “doctor”
- Touches genitals, breasts or buttocks of same-aged child or has that child touch them
- Tries to view others naked
- Puts objects in genitals/rectum for curiosity or sensation

# Age 6-9: concerning sexual behaviors

- Wants to masturbate to nude pictures
- Sexual behaviors that involve force or coercion
- Sexual behaviors between children that are more than 4 years apart in age
- Sexual behaviors that cause physical pain or emotional distress, that are obsessive, or that result in anger/aggression when redirection is attempted
- Intercourse with another child

# Factors other than CSA that may influence sexual behaviors

- Exposure to pornography
- Exposure to intimate partner violence or sexuality
- Experiencing other maltreatment:  emotional abuse, neglect, physical abuse

# How Do I respond?

- Gain understanding of caretaker concerns
- Ensure review of comprehensive health history and appropriate review of systems
- If appropriate, narrative interview with child/forensic interview
- Appropriate physical examination and identification of medical conditions
- Determine if reporting threshold has been reached and whether emergent specialized medical care is indicated (SANE exam)

# Resources

- https://www.suffolkcac.org/uploads/pages/docs/Understanding_CSB_Trifold.pdf
- http://www.ncsby.org/

Child Sexual Abuse

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http://pedsinreview.aappublications.org/

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# Child Problem Sexual Behavior

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# Objectives

- Define child problem sexual behavior (PSB)
- Teach team members (SANEs/PLN staff) the basics behind youth who cause sexual harm
- Discuss treatment goals and effectiveness of treatment
- Explore safety planning

# Problem sexual behavior

- Any sexual act that is hurtful to another individual or any sexual act defined as illegal by the criminal statutes of the jurisdiction in which the behavior occurred (Chaffin, Bonner, & Pierce, 2003).

- Youth with problem sexual behavior are under the age of 18, or 21 (depending on the jurisdiction ) who have caused sexual harm to others through verbal, emotional, and/or physical means.
  - Behavior may or may not meet criminal codes defining illegal sexual contact.

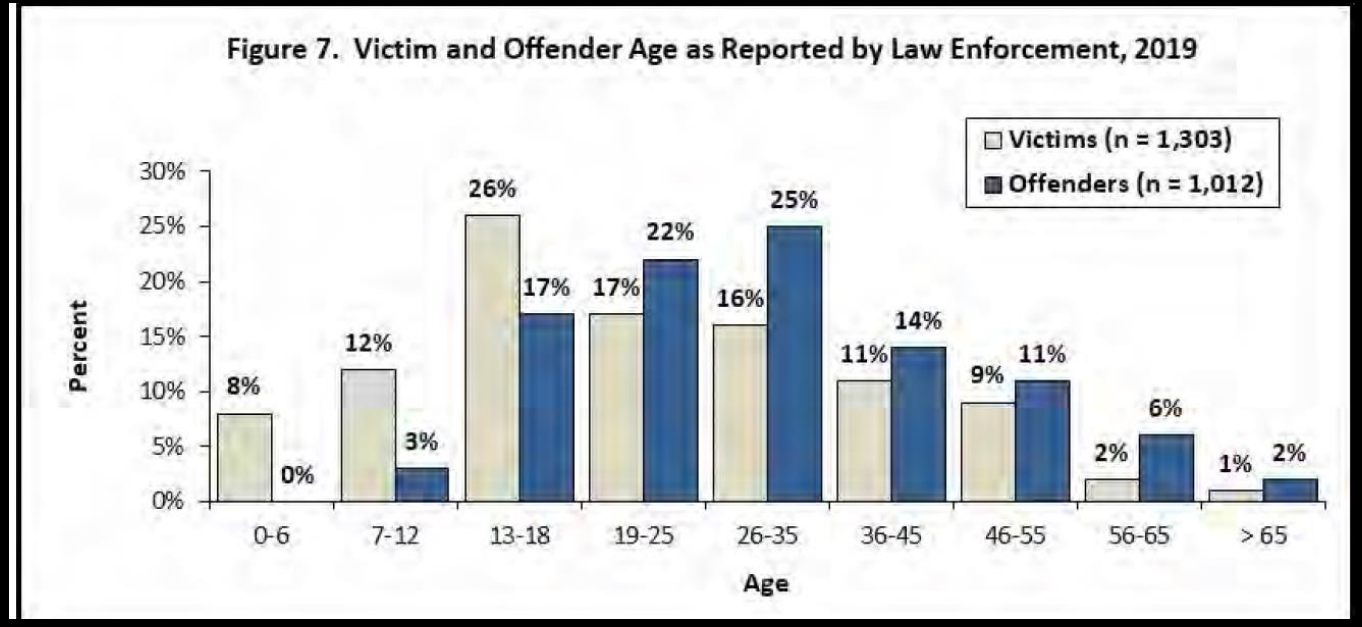
# Scope of the problem

- Sexually abusive behavior by adolescent youth is a serious public health, public safety, and public policy problem.

- Adolescents commit >1/3 of all sexual offenses against minors.
  However, the percent of adolescents committing these offenses is low: ~ 4 to 5% of teen males and ~1 percent of teen females have perpetrated acts of sexual abuse. (ATSA, 2017)

# Trends and history

- Is kid on kid/child problem sexual behavior a new thing?
- We know this number is likely much much higher




Courtesy Dr Betty Caponera's annual report for the state of NM 2020

# Why do kids sexually harm other kids?

- Behavior is communication. What are they trying to tell you?
- Could it be big traumas need big reactions?

# Trends in sexual reactivity (why do some kids respond in a sexual manner)

- Witness abuse (any kind)
- Witness sex
- Pornography exposure
- Maltreatment
  - sexual, physical, neglect, emotional

# What is trauma?

- “Deeply distressing or disturbing experience that has a lasting effect on function and well-being”
  - Effects executive functioning
  - Results in arousal dysregulation
  - Maladaptive procedural learning
  - Impulsivity
  - Harm to self and others
  - Disruption in memory, attention, irritability, sleep

# Trauma

- Can begin before birth
  - Fetus bathed in stress hormones
- How we respond to trauma is mediated by the structures in the brain and mind we have in place at the time of the experience
  - “Immature responses” to trauma
- Medications can help
  - They do not teach the lasting lessons of self-regulation

# Universal Assumption

- Universal assumption of trauma in problem sexual behaviors
- Like universal precautions
- “What happened to bring you to my office”
- Don’t ask “what’s wrong with this child”, ask “what happened to this child?”
  - Bad seed?  Maybe.
    - Incidence of antisocial personality disorder is 0.2-3.3% (no longer use the term sociopath, psychopath) (APA, 2013). Most children with APD have a history of trauma

# Body Responses to Trauma

- Fight
- Flight
- Freeze
- Fawn

# What is fawning?

- “Immediately moving to try to please a person to avoid any conflict. Often a response developed in childhood trauma where a parent of an authority figure is the abuser.
- Children go into a fawn-like response in an attempt to avoid the abuse, which may be verbal, physical or sexual, by being a pleaser” (Gaba in Psychology today, posted 8/22/20)
- Children can fawn with other children

# Motives for Causing Sexual Harm

- There is no absolute motive. The behavior serves some purpose
- Attention, control, release anger, chemical release of dopamine, calm the internal system, distraction, affect regulation
- Teens are fundamentally different than adults that offend

# Problem Sexual Behavior in General

- Is not a pleasure seeking behavior (goal is not orgasm or sexual pleasure)
  - Parents get very upset thinking that their child was used for sexual pleasure and that is not the true motive
- “I am trying to soothe my brain and regulate my own system”
- “Might sexually offending youth be seeking the sensory INTENSITY to help calm themselves down?”
  - Touching my sister helped me feel better last time (reinforcing)

# Teens who cause sexual harm

- Teens who commit sexual offenses are more likely to have been sexually victimized or exposed to porn at an early age themselves
- Report higher levels of social isolation, anxiety and low self-esteem
- LESS likely to have criminal histories, associate with antisocial peers or have substance use problems vs. other teens who have committed non-sexual crimes

# Treatment

- Includes adding things, not taking things away (outings, phone, access to cousins)
  - Adding is not the same as rewarding

# What treatment teaches the child

- What are your cues?
- Stressed- I eat
- Sad- I shop
- Rejected- I drink
- Mad- I masturbate or touch my sister

- Kids have fewer choices when it comes to a behavioral response
  - Harm self or others

# Sexuality education

- Sex incredibly hard to understand when you have been abused yourself
  - Confusing
  - Was I asking for it?
  - Am I gay? Is that all I am good for?
  - It was dirty, everything is dirty

# Treatment Method (All Faiths, Albuquerque)

- PSR- Practice Self Regulation (Joann Schladale)
- Practiceselfregulation.com
- Specialized therapy, 8 sessions directed towards correcting problem sexual behavior

# Sessions Overview

- 1. Choices
- 2. Your life experiences
- 3. Bad things that happen in life
- 4. Looking for love in all the wrong places
5. The trauma outcome process
6. Taking good care of  yourself
7. Becoming the person you want to be
8. Pursuing your dreams

- Child completes workbook reflections after which the therapist runs a multisensory activity that corresponds to the workbook

# Effectiveness of Treatment

- Therapeutic interventions are more effective and more cost-effective than social controls (ATSA, 2017)

# What if the Child is not Actively Engaged in Treatment?

- Denial of the behavior is expected
- Low victim empathy is not a risk. It is common and not alarming (They don’t need to appear sorry to benefit and grow)
  - Are they from a violent environment? Could empathy be seen as weak? Have they ever been shown empathy? Maybe they don’t feel what they did is wrong.

# Risk of Reoffending

- “Determining the specific level of risk for re-offense of sexual harm is currently statistically impossible and unethical. Currently there are no empirically validated measures for determining specific probability of youthful sexual re-offense. Multiple factors make this impossible”
  - The fluid nature of child and adolescent development
  - Low base rates of sexual recidivism among youth
  - Lack of consensus in defining predictors of recidivism
- “Thus the goal is to build on strengths in order to reduce harm and increase potential for successful treatment”

# Risk of Reoffending as An Adult

- Most children who cause sexual harm *can* be redirected and rehabilitated
- Most children who cause sexual harm do not continually abuse and are not on a lifelong trajectory for repeat offending
- Recidivism rates are low (3-10% with a global average of 5%) (ATSA, 2017)

# Challenges with cohabitation

- So you are just going to leave these children together in the same home???
- Often YES!
- Reduce trauma
- Can be done safely with parent engagement

# Safety planning if the children stay in the same home

- Requires positive collaboration between family and protective services
- Sleeping arrangements- children with PSB should not sleep in the same room with the child involved. Ideally sleep on other ends of the house. Parents can co-sleep
- Being left alone together? NO
- Privacy respected for everyone
- Parental controls on devices
- Consider Alarms on doors and windows. Require door locks
- Frequent check ins
- Therapy for all children involved
- In home services

# SafeCare NM ECHO Telehealth/Mentoring Program

- What is Project ECHO
  - Healthcare initiative launched from UNM in 2003
  - Original program focused on improving access to care for patients with Hepatitis C
  - https://hsc.unm.edu/echo/about-us/

  - Has grown to thousands of programs in US and internationally

# The Principles of the ECHO Model

- **Amplification** - use technology to leverage scarce resources
- **Best practices -** to reduce disparity
- **Case-based learning** - to master complexity
- **Data:**-monitor outcomes with our web-based database

# SAFE CARE New Mexico TeleECHO Program

Creating a community of practice among pediatricians to help them serve children throughout New Mexico

- Provide training for physicians, advanced practice providers and physician assistants on the forensic evaluation and comprehensive medical care of children who are alleged victims of child physical abuse or sex abuse

- Provide mentorship, support and ongoing education for a network of providers that take an active role in providing these services to children in their communities

- Empower multidisciplinary team members to better recognize and respond to child abuse and neglect through education on injury mechanics/plausibility, sentinel injuries and other medical aspects of child abuse and neglect

# SafeCare NM

- Launched May 2020
- Brief Teaching Session followed by case review
  - Season 1 (Summer 2020) Education Focus:  Child Physical Abuse and Neglect
  - Season 2 Education Focus (Winter/Spring 2021):  Child Sexual Abuse
  - Season 3 Focus (curriculum under development) for fall 2021

# SafeCare NM Participation

- Gallup
- Taos
- Las Cruces
- Grants
- Albuquerque
- Roswell
- Santa Fe

- Participants
  - Health Care Professionals
  - Social Work
  - Forensic Interviewers
  - Child Protective Services
  - Law Enforcement
  - Judiciary
  - Students

# SafeCare NM Meets

- 1st and 3rd Thursday of each month from 8:00 – 9:00 AM via Zoom
- Continuing education credits are offered for participants in medicine, nursing, and social work
- For more information or to join: SafeCareNMECHO@salud.unm.edu

# The University of New Mexico
# Child Maltreatment Prevention Symposium

Live Online or In-Person April 20th & 21st

Every April, communities across the nation come together to discuss the problem of child maltreatment and ways to prevent it. The University of New Mexico Injury Prevention Task Force and the Child Health Research Signature Program invite clinicians, researchers, and community providers to join us in presentations and interactive discussions on child maltreatment risk and protective factors, successful community intervention programs, and ideas for collaborative study and engagement.

## WHAT YOU'LL LEARN

In addition to acquiring a deeper understanding of the topics listed in the course objectives, the conference's interactive platform will provide students with opportunities to engage with like-minded professionals for potential collaborative project endeavors.

- Participants will recognize links between social determinants of health and child maltreatment reports and prevalence.

- Participants will understand principles of injury control and prevention that are foundational to program development.

- Participants will recognize risk and protective factors for child maltreatment, and become aware of supportive community resources and programs.

## WHO SHOULD ATTEND

Injury prevention specialists, child maltreatment service providers, and child health professionals.

**THIS IS FREE BUT YOU MUST REGISTER AT http://ce.unm.edu/cme OR USE QR CODE.**

**COURSE PROVIDES UP TO 8.5 FREE CEU OR CME CREDITS**

**ADDITIONAL INFORMATION CAN BE FOUND BY USING THE LINK OR QR CODE**