

# Understanding and responding to problem sexual behaviours in children

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## Background

One of the determinants of successful service engagement to address problem sexual behaviours in children is the response when a parent/carer first discloses the behaviour, often to a trusted professional such as a teacher, allied health professional or the family general practitioner (GP).

## Objective

The objective of this article is to guide the response of medical professionals to parents/carers of children exhibiting problem sexual behaviours, to increase the likelihood of successful support service engagement.

## Discussion

Problem sexual behaviours in children can be a predictor of trauma or abuse, and their discovery can have a devastating impact on parents and families, sometimes leading to denial, blame, rejection and relationship breakdown. Understanding parental reactions, using correct terminology, and responding with sensitivity and understanding can increase the likelihood of successful service engagement and intervention.

**USING THE CORRECT** terminology to describe sexual behaviours in children is important as language that labels the child can be harmful.<sup>1</sup> There is broad agreement among academics and practitioners working to understand and address these behaviours that the use of stigmatising terms, such as 'sex offender', 'perpetrator' or 'abuser' (taken from the adult field), leads to a negative self-identity and reduced motivation to change.<sup>2,3</sup> Terminology describing the behaviour rather than the child is appropriate, and the terms 'problem sexual behaviours' (PSBs) and 'sexually abusive behaviours' (SABs) are widely used in accordance with the age of criminal responsibility (Box 1).<sup>2</sup>

## Normal versus problematic sexual behaviours

Studies indicate that 50–73% of children engage in sexual behaviours in childhood, including behaviours that involve other children.<sup>4</sup> Determining the prevalence of PSBs is difficult as no clear universal definition of what constitutes PSBs exists, and many PSBs go unreported.<sup>5</sup>

Identifying whether sexual behaviours are problematic, as opposed to developmentally normal sexual play and exploration, requires consideration of a range of factors. Key factors include an understanding of what constitutes normal sexual behaviour for a child of a given age, the developmental level of the child and the context of the behaviours.

Childhood sexual behaviours considered 'normal' are spontaneous, intermittent, mutual, non-coercive and non-distressing interactions between children of a similar age.<sup>6</sup> It is also normal for younger children (2–5 years) to be curious about the bodies of adults,

particularly of the opposite gender.<sup>7</sup>

Normal childhood sexual behaviours are driven by curiosity and experimentation. They occur in the context of a sense of play, are readily redirected and require no professional intervention.<sup>8</sup>

Sexual behaviours may be considered problematic if they target a more vulnerable child, are persistent, distressing to others or are resistant to normal parental correction and boundary setting.<sup>7</sup> Sexual behaviours that exceed developmental bounds include behaviours demonstrating greater sexual knowledge, interest and experience-seeking than is normal for that child's developmental level.

As Case 1 highlights, it is important to consider the context of the behaviour when determining whether a behaviour is concerning.

### Box 1. Sexual behaviours in children: Correct terminology

- **Problem sexual behaviours (PSBs):**

This term refers to problematic sexualised behaviours in children below the age of 10 years, and recognises that a child under the age of 10 years is considered *doli incapax*.

- **Sexually abusive behaviours (SABs):**

This term applies to children and young people aged 10–18 years who have engaged in harmful sexual behaviours.

- **Children who are targets of PSBs or SABs:**

This term refers to children towards whom problem or abusive sexual behaviours have been directed, and replaces the term 'victim'.

This terminology recognises that the behaviours are transitory and that children are developing and vulnerable, and require a supportive intervention.<sup>1,5</sup>

**CASE 1**

Cathy, a single mother, had her two sons, aged six years and four years in the bath together when she overheard the six-year-old asking the four-year-old to let him play with the younger boy's penis. Cathy dismissed the behaviour as normal curiosity and play for boys of their age, but became appropriately concerned when the younger boy, after wetting the bed one night, told her that his older brother had entered his bedroom during the night, engaged in the same behaviour as he had in the bath and told him to keep it a secret.

Cathy immediately banned the boys from bathing or changing together and entering each other's bedrooms. Cathy set up a temporary mattress in her room for her younger son to sleep on and contacted a local family support service.

Child protective services were notified. They visited the home but determined that Cathy was acting protectively so referred her back to family support services and to a sexual assault service for assessment and intervention.

The assessment identified that the boys experienced a punitive parenting style on access visits with their father and recently had inadvertently been exposed to sexual material inappropriate for their ages. It was also found that Cathy had not been fully attuned to the boys' distress because of time devoted to her online selling business. Both parents addressed their parenting approaches and implemented appropriate household rules regarding play and bathing.

## Understanding the behaviours

A range of factors can lead to PSBs, and complex factors are frequently present. Psychological and emotional problems are common, and there is a high frequency of comorbid diagnoses such as depression, anxiety, conduct disorder, attention deficit hyperactivity disorder (ADHD), oppositional defiance disorder (ODD), autism spectrum disorder (ASD), poor emotional regulation, impaired attachment and developmental or learning delay.<sup>4,5,8,9</sup>

Other commonly identified factors include exposure to age-inappropriate sexual material or language, sexual or physical abuse, family stress or dysfunction, neglect, exposure to pornography, family violence, drug and alcohol abuse, homelessness, unstable care arrangements, inadequate supervision, a highly sexualised environment, low socioeconomic status and social isolation.<sup>2,5,6,8-11</sup>

Over 50% of children exhibiting PSBs have previously experienced sexual abuse,<sup>5</sup> including having been the target of PSBs themselves, and up to 50% have experienced physical or emotional abuse. There is a significantly higher likelihood that girls who engage in PSBs have experienced sexual abuse.<sup>5</sup>

Children can also engage in PSBs in the absence of complex factors, such as when a child is mimicking adult sexual behaviour they have observed. However, problematic sexual behaviours are more commonly derived from feelings of powerlessness or fear, the need to self-soothe or self-regulate, the desire for attention or a re-enactment of sexual abuse.<sup>6,8,12</sup>

**CASE 2**

Jason, eight years of age, engaged his four-year-old nephew in a game of 'hide and seek' during a family gathering. He hid in a cupboard with the younger boy and engaged in oral sexual contact.

Jason lives with his single mother, Alice, and two younger siblings, who have a different father. Jason was exposed to his own father's anger, belittling comments and rejection. After his parents separated, Jason's contact with his father was intermittent and marked by conflict; eventually it ceased almost entirely.

Jason began building a positive connection with his mother's next partner, who subsequently also separated from his mother; Jason's half siblings regularly saw their father, but Jason was not included in their visits.

Alice did her best but was preoccupied with the younger children, whose behaviours she found extremely difficult to manage, so it suited Alice that Jason spent his time in his room with his play

station and laptop computer. Jason was withdrawn, had low self-esteem and had been diagnosed with anxiety.

Child protective services investigated and implemented a safety plan, then referred Alice to local family support and sexual assault services. Alice received personal counselling, in-home support and access to a parenting program. Jason received individual counselling, and joint counselling with Alice and Jason helped Alice better understand Jason's needs and strengthen their relationship. Contact between Jason and his siblings' father increased. Child protective services withdrew after being satisfied that Alice was making satisfactory progress.

## Disclosures and their impact

The impact of PSBs on a child can be similar to that of sexual abuse by an adult;<sup>8</sup> however, only a small percentage of children disclose being sexually targeted by another child or young person.<sup>13</sup> It is common for children to falsely deny having been targeted by a sibling,<sup>8,14</sup> and disclosures are commonly retracted once a child sees the impact and consequences of their disclosure on the family.<sup>8</sup> Children are unlikely to disclose having been the target of PSBs or SABs even when the behaviours are serious and include penetration.<sup>8,13</sup> Discovery of sibling PSBs is more likely to be the result of inadvertent adult observation or through parental investigation of a child's unusual behaviour pattern or an alarming comment.

A disclosure of PSBs towards a sibling can be devastating for a family and may leave parents/carers experiencing disbelief, confusion, shock, grief, shame, despair and self-blame.<sup>2,13</sup> While many parents respond appropriately to a disclosure, others are avoidant and may deny or minimise the disclosed behaviour. This may be due to a lack of understanding about developmentally appropriate sexual behaviours, uncertainty about how to respond, shame, self-doubt, fear of being judged a bad parent, feeling overwhelmed by other personal crises, fear of the impact on their family or fear of the consequences of statutory involvement.<sup>2,8,14</sup>

Strong reactions can be driven by the holding of an adult 'sexual abuse' framework that guides thinking and reactions<sup>15</sup> or a parent/carer's own sexual abuse history triggered by the disclosure. These factors may also lead to a reactive and overly punitive response that includes rejection of a child.<sup>8</sup> When the child who engaged in PSBs is not a member of the family, the targeted child's parent/carer is far more likely to experience anger and report the behaviour to authorities.<sup>16</sup>

A disclosure may lead to conflict and division in families and even to relationship breakdown.<sup>13</sup> Conflict can occur over differing beliefs or interpretations about what happened, how to respond, who is to blame or whether to report. In many cases relationships are already fractured, and the disclosure is simply the catalyst for relationship breakdown.

## Responding to a disclosure

A parent/carer's response to PSBs is important in the recovery of all affected children, as is parent/carer involvement in addressing the behaviour.<sup>2,6,11,14,17</sup> Given the potential for a reactive parent/carer response that may include avoidance or the rejection of a child,<sup>8</sup> the initial response by a professional is critical and, if handled well, can build hope and pave the way for positive service intervention and outcomes.<sup>17</sup>

A parent/carer rarely knows how to go about seeking advice regarding their child's sexual behaviours and may initially, and sometimes tentatively, raise concerns with a teacher, GP or allied health worker. Sometimes concerns are not directly raised by a parent/carer but may be uncovered when an astute professional identifies red flags such as multiple significant risk factors, an unusual comment or 'partial' disclosure that they explore more deeply in the context of genuine interest and curiosity.

The presence of risk factors, such as those mentioned earlier, may prompt a helpful professional response such as, 'You have an enormous amount on your plate right now, and what you and your family are going through can be tough on everybody, particularly children. How do

you feel they are coping? Can you tell me about any concerns you have regarding the children?'

Follow-up questions may be, 'Are there any particular behaviours you are concerned or worried about, or that don't seem completely normal?' and, 'Can you tell me more about what you've noticed?' If sexual behaviours are identified as a concern, greater detail regarding the behaviours may be uncovered with more targeted questions such as, 'Can you tell me exactly what your child was doing/saying?'

To increase the likelihood of families willingly engaging with professional services once PSBs are identified, it is important for professionals to convey sensitivity, warmth, empathy and hope while remaining calm, clear and honest.<sup>8,15</sup> Professionals need to congratulate parents/carers on what they are doing well and avoid implying judgement or blame.<sup>8</sup> Plain language consistent with a child development framework, rather than an adult 'sexual abuse offender/perpetrator' framework, is critical.

Parents/carers often seek direction at this early point in a crisis and may respond well to clear instruction about what needs to be done.<sup>14</sup> Some may feel overwhelmed and unable to cope,<sup>8</sup> so acknowledging how hard this must be and letting them know that parental support is part of a service response can be helpful.

The children involved do not need to be seen unless there are medical concerns and, to minimise distress, no child should be present for consultations between the parent/carer and professional about the behaviours.

## Summary

Developmentally normal sexual behaviours are driven by curiosity and experimentation and are spontaneous, mutual, non-distressing, non-persistent interactions between children of a similar age, and the child can be easily redirected. Sexual behaviours are considered problematic if they exceed developmental bounds, are persistent, distressing for the other child or resistant to parental intervention.

PSBs frequently occur in the context of complex factors including inadequate

supervision, abuse, family instability and dysfunction or exposure to family violence, drug or alcohol abuse or inappropriate sexual material. PSBs may indicate a child's distress, anxiety, need for attention or experience of sexual abuse.

Disclosures can have a devastating impact on families and may result in denial, confusion, shame, guilt, anger and even relationship breakdown. It is important for professionals to respond to family members with clarity and honesty in a way that is calming, supportive, sensitive, warm and conveys a sense of hope. It is important to use language that is consistent with an understanding of child development rather than a sexual abuse/abuser framework.

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