FOSTERING DIFFERENCE

PROBLEM SEXUAL BEHAVIOUR IN CHILDREN

How to Identify and Respond to Problem Sexual Behaviour in Young Children

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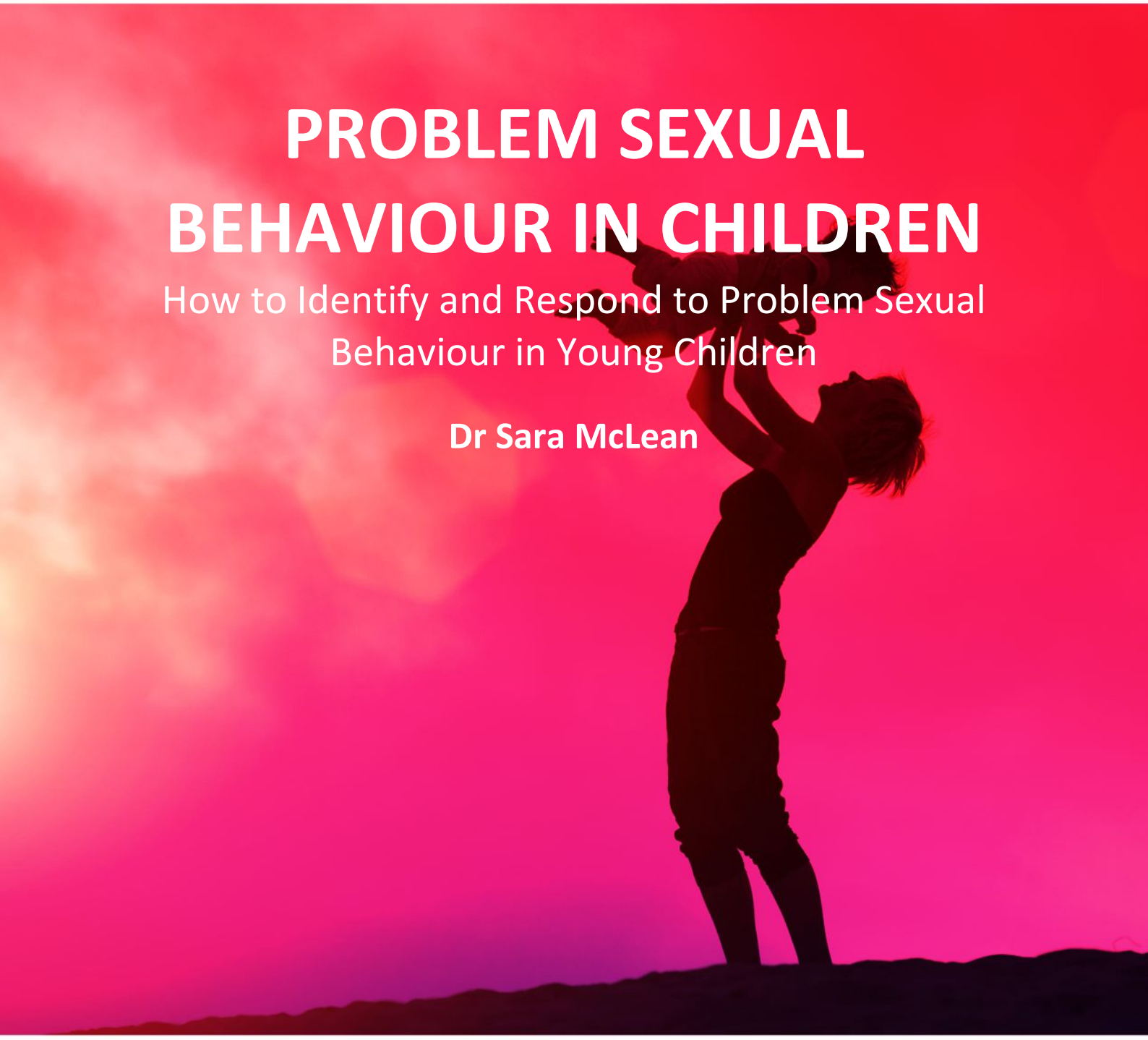

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'Childhood should be carefree, playing in the sun; not living a nightmare in the darkness of the soul'

Dave Pelzer, A Child Called 'It'

Acknowledgment:

This resource is part of a series of resources for foster parents who are raising children living with developmental difference caused by early life adversity. The guides are intended to provide general educational information only, and are not a substitute for professional assessment and intervention.

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Problem Sexual Behaviour and Childhood Sexual Abuse

Caring for a child who has been sexually abused can be challenging. Childhood sexual abuse is surprisingly common. Most research tells us that around 1 in 5 females and almost 1 in 10 males encounter sexual abuse before the age of 18. The number may be even higher for children who are placed in out-of-home care. Although not all children who have been sexually abused go on to display concerning sexual behaviour, many do. It is also important to emphasise that not all children who display problem sexual behaviour have been abused.

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What is Sexual Abuse?

Sexual abuse is usually defined as using, or allowing, a child to be used by a person; either directly or indirectly, for the purposes of sexual activity; and where there is unequal power between the child and the perpetrator.

Types of sexual abuse include exposing the child to sexual images or pornography; allowing the child to witness sexual activity; making them take part in non-penetrative touching and masturbation; or making them take part in oral, genital or anal penetrative sex.

The impact that sexual abuse has on a child varies enormously; depending on the child's relationship with the abuser; whether the abuse is accompanied by threats of harm or other threats; whether the child experiences feelings of guilt or betrayal; and depending on the age and emotional development of the child at the time of abuse.

It is extremely distressing to think of these kind of things happening to a child. If you are fostering a child with suspected history of sexual abuse, it is likely (although not certain) that at some stage you will encounter problematic sexual behaviour from your child. But remember there are also many other reasons for sexual behaviours. For example even older children can use sexual behaviour as an attempt to self-regulate, or relieve anxiety; rather than for gratifying 'sexual urges *per se* (see the resource in this series 'Guide to Managing Behaviour').

Irrespective of the cause, sexual behaviours from children can be very upsetting; and they do need to be managed safely and with care.

What are Problem Sexual Behaviours?

Foster parents are most concerned when children are:

- Touching their genitals excessively or masturbating.
- Behaving in pseudo-adult, flirtatious, or seductive manner.
- Touching themselves or masturbating in public.
- Having poor personal boundaries, being intrusive.
- Being excessively interested in looking or touching private areas of adults in family.
- Becoming sexually aroused when close or cuddling adults.
- Showing excessive interest in sexual play.
- Talking about the details of their sexual experiences.

Remember that not all sexualised behaviour in children is related to past abuse. Some behaviours that *appear* sexual in nature (e g., masturbation) can be related to the child's need to self-soothe, and their inability to soothe in other ways.

Sexualised behaviour can be challenging. Sexual behaviour from young children can confront our values and morals. Our ability to distinguish between the *behaviour* and the *child* is critical. Although these 'adult-like' behaviours can be confronting and shocking; it is important to try to keep in mind the difference between bad behaviour and bad intentions. Your child may be 'behaving badly' but is not a 'bad kid'.

Later in this resource we list a range of normal and concerning sexual behaviours for each age group. This list can be helpful in determining whether professional support and monitoring should be put in place for your child. The remainder of this resource provides general guidelines for caring and supporting the child with concerning sexual behaviours in your home.

Guidelines for Supporting your Child

It is useful to remember that sexual behaviours in young children are often not motivated by sexual urges per se. This means these behaviours can usually be replaced by other behaviours once you address the child's underlying need (see 'Foster Parents' Guide to Behaviour Management'). Not all sexually concerning behaviours require therapy. Some, particularly those associated with anxiety, will diminish over time as the child feels safer and learns other ways to self-regulate.

However, sexually concerning behaviour should *always be taken seriously* and *monitored* over time. It will be important to ensure your support worker and your child's case worker knows about these behaviours and that your child is *supervised* at all times. If your child is displaying sexualised behaviours, the following guidelines may be useful:

- Try to understand the link between your child's past trauma and your child's current behaviours;
- Become familiar with normative and non-normative sexual behaviour in children in order to identify problem behaviour and uncover clues to past abuse,
- Take steps to modify the home environment to minimise opportunities for sexualised behaviour and to ensure that you and your family are kept safe;
- Develop an action plan for responding to concerning sexual behaviour and share this with your support worker and family members;
- Consider obtaining therapeutic support for your child at the appropriate time (when your child is ready).

Understand the connection between past abuse and present behaviour

You may or may not know about your child's past abuse. Unfortunately sometimes foster parents report they are not told whether or not sexual abuse has occurred or is suspected. In many instances, observing your child's behaviour may provide clues. The range of behaviours associated with past sexual abuse can vary widely. However, some of the behaviours commonly found amongst children who have experienced sexual abuse include:

- Sudden and unexpected panic or rage reactions; apparently 'out of the blue', and unrelated to any obvious trigger. These reactions can often be traced to reminders of the sexual abuse that 'trigger' a child's panic reaction.
- Extreme fear of a range of 'normal' daily situations (for example bathing, showering, getting tucked into bed; going to sleep, being in a room when the door is closed, being in a room with the light out, being 'shut in' or in a confined space). Having extreme or unusual reactions to objects and people that remind the child of unwanted sexual activity.

- Distressing behaviours including excessive or public masturbation; engaging in 'flirtatious' and 'provocative' behaviour towards others; becoming sexually aroused by being close to an adult (for example when cuddling); or engaging in sexual play or acting out with other children.

The way that sexual abuse affects each child is different, depending on their unique circumstances. Children can show extreme fear reactions, or they may re-create the abuse through play or behaviour that casts you (or your partner) in the role of the perpetrator. Any of the above behaviours should act as red flags and should be brought to the attention of your support worker and the child's worker. More specific sexual behaviours are detailed in the section on normative and non-normative sexual behaviour in children (below).

Modify the home environment and routines to ensure the safety of all family members

Caring for a child with sexualised behaviours will mean significant adaption to your home and family life. If you are caring for a child with known or suspected sexualised behaviour it is critical to maintain adequate supervision of your child. This is especially important around other children. Raising a child with sexualised behaviours can also place a significant strain on your family relationships and your partner. For example, you may need to talk to your other children about issues that you would rather they weren't aware of. You will need to enlist the entire family in ensuring appropriate boundaries and safety rules are put in place.

There are two main risks involved in caring for a child with sexualised behaviours. 1) The risk of exposing family members to unwanted sexualised behaviour or sexually explicit material and 2) The risk of exposing adults in the family to allegations of inappropriate sexual conduct towards their foster child.

These are real risks but can be minimised by having a good safety plan and by good communication with your child's social worker. If you think there is a risk that you may be subject to a false allegation, then you will need to be especially cautious. At the same time, it is important to try to maintain as calm and normal a family environment as possible (no easy task!). While every situation is different, there are some general approaches you can put in place to minimise risk.

First, it is unwise to agree to foster an older child known to have problematic sexual behaviour if you have young children in the home. Young children, especially those with limited verbal ability, are more at risk of being exposed to unwanted sexual behaviour, or inappropriate sexual material, than older and more capable children. Older and more able children can remove themselves from problem situations, or report problem behaviour. Children with a disability may be more vulnerable to exploitation for the same reasons that young children are.

Instigate rules that the whole family must abide by. This will minimise risk, especially when you are caring for more than one child. For example, children and adults can agree to always knock before entering 'personal' spaces such as bedrooms, bathrooms or toilets. Ensure the rules you put in place are explained to- and applied to-*all family members* -so that the child with sexualised behaviour doesn't feel singled out. When bathing very young children, for example, there could be an agreement that the bathroom door always remains open and/or that both adults are present/ nearby when bathing occurs. It is important to balance the need to protect your family from potential harm, and the need to treat children as normally as possible. This is certainly not always easy to do.

As a general rule, many of your daily routines will need to be reviewed to ensure the emotional and physical safety of all family members and visitors to your home. For example:

- Teach and model privacy and respect. Make it a rule to knock before entering bedrooms and bathrooms.
- Take extra precautions to ensure that adult sexuality, and adult bedrooms are kept private; while modelling appropriate displays of affection between adults.
- Take extra precautions around potential triggers for children (bedtime, bedrooms, bathrooms- these are often places in which abuse has occurred in the past).
- Supervise the child with known difficulties at all times with other children.
- Ensure children sleep in their own beds, and ensure they dress/undress in private.
- Show and tell your child how you want them to behave- tell them what to do instead of the sexualised behaviour (for example; "When we cuddly we put our arms here").
- Share your plan with your support worker. Ensure your support worker and the child's caseworker know your concerns and how you are addressing these concerns. It is best to have an email record of these discussions and concerns where possible.

Have an Action Plan for Responding to Concerning Sexual Behaviour

Develop, and rehearse, an action plan for responding calmly to problem sexual behaviour. This should include a plan for identifying to the child the specific behaviour that is unacceptable; include a clear and age appropriate statement about your expectations; and an instruction to the child for an alternative behaviour that either distracts the child or enables them to address the need underlying the behaviour. An example action plan could look something like this:

1. Notice and stop the child:

You need to convey to the child directly the need to stop the behaviour. You can remove the child's hand, push the child gently away, separate the children, or divert the child's attention away from the concerning activity or material (depending on the age of the child). Ask the child to stop doing what they are doing in a calm way.

2. Name the concerning behaviour:

Tell the child directly what they are doing "wrong" and why. For example "you are touching yourself in the kitchen. Touching is for when you are alone". Or "You are touching my private parts. My private parts are for me to touch". Remain calm and avoid using emotive and shaming words such as "bad" or "naughty"; instead tell them what behaviour "Is not ok".

3. Tell the child your family rule or expectation:

State your family expectations and rules. For example "In our family we hug when we want to feel close" or "In our family, we go get undressed in the bedroom" The aim is to offer your child a better understanding of normal family and social behaviour.

4. Provide and alternative or distract the child

Younger children can often be distracted from inappropriate behaviour where this is due to curiosity rather than sexual urges. Older children may need to be re-directed to an acceptable alternative; for example "Why don't you go to your bedroom if you want to put your hands down your pants?" Tell the child what you want them to do instead of what they are doing now.

Sometimes sexual behaviours can be adopted for reasons other than the obvious sexual motive. For example, a child may equate sexual touching with being close to a caregiver, or with self-soothing, and in this case you may need to teach an acceptable alternative soothing behaviour (for example-"I like being close to you too; but in this family we cuddle with our hands up here").

5. Let your support worker know your concerns

It is important to make a record of any concerning behaviour and to advise your support worker and the child's case worker so that they are aware of the behaviours. A record of ongoing behaviour can provide useful information about the pattern of a child's behaviour and potential triggers. These records can be useful in advocating for therapeutic support. It can be useful to use email or similar written communication to document your concerns.

Become Familiar with Normal and Concerning Sexual Behaviour

It is easier to remain calm in the face of sexual behaviour from a child when you have a good idea about what normal and concerning sexual behaviour looks like. *Not all sexual behaviour is problematic*. Remember children who have not been abused engage in sexual exploration and are sexually curious. If you haven't raised other children it can be helpful to talk to other parents about normal sexual curiosity and the kinds of 'ages and stages' that all children go through.

The following is a guide to normative and non-normative sexual behaviour in children. Please remember it is a guide only, and is not meant to be exhaustive. Any behaviour that you are concerned about should be discussed with your support worker and your child's caseworker.

Children Aged 0-4 years:

Normal sexual behaviours:

- Touching or rubbing their own genitals; unselfconscious masturbation.
- Enjoying being nude, comfortable without clothes.
- Showing interest in the look and function of body parts (self and others).
- Showing others their genitals; playing "show me yours and I'll show you mine".
- Asking about, touching or asking to see the private parts of familiar adults.
- Playing 'doctors and nurses' or 'mummies and daddies'.
- Using slang words/dirty language for bathroom and sexual functions, talking about 'sexing'.
- Showing interest in people doing bathroom functions.

Concerning sexual behaviours:

- Persistent masturbation that does not cease when told to stop; masturbation in preference to other activities.
- Persistently watching others in sexual activity, toileting or when nude; following others into toilets, bathrooms to look at them or touch them.
- Touching the genitals/private parts of other children in preference to other activities.
- Touching the private parts of adults not known to the child.

- Explicit sexual talk, art or play.
- Pulling other children's pants down or skirts up against their will.
- Forcing another child to engage in sexual play; sexualised play with dolls.
- Touching the genitals/private parts of animals after being re-directed.
- Persistently wanting to be nude in public.
- Persistently asking about genital differences despite questions having been answered.

Highly concerning sexual behaviours:

- Persistently touching or rubbing themselves to the exclusion of normal childhood activities; hurting their own genitals by persistently rubbing or touching.
- Simulating sex with other children, with or without clothes on.
- Sexual play involving forceful anal or vaginal penetration with objects or oral sex; simulation of sexual touch or sexual activity; penetration with objects; masturbation of others.
- Persistent explicit sexual themes in talk, art or play.
- Disclosure of sexual abuse.
- Persistently touching the genitals/private parts of others.
- Forcing other children to engage in sexual activity.
- Presence of a sexually transmitted infection.

Children Aged 5-12 years:

Normal sexual behaviours:

- Occasional masturbation, but with awareness of privacy.
- Curiosity about other children's genitals that involves looking at or touching bodies of familiar children; playing "show me yours and I'll show you mine" with same age children.
- Curiosity about sex; questions about babies, gender, sexual activity.
- Touching and holding own genitals.
- Mobile phone use with friends.

- Hearing and telling age-appropriate dirty jokes; simple jokes about sex shared with peers.
- Kissing/holding hands.
- Occasional mimicking or practising observed behaviours such as pinching a bottom.

Concerning sexual behaviours:

- Masturbation in preference to other activities, in public, with others and/or causing self-injury.
- Mutual masturbation with another child.
- Explicit talk, art or play of sexual nature.
- Persistent nudity and/or exposing private parts in public places; touching self in public.
- Persistently mimicking sexual flirting behaviour too advanced for age, with other children or adults.
- Continually wanting to touch the private parts of other children; pulling other children's pants down or skirts up against their will; attempting to expose another child's genitals.
- Wanting to play sex games with much different age child; simulating sex with peers.
- Touching genitals/private parts of animals after being asked to stop.
- Persistently asking about sexuality despite questions having been answered.
- Use of mobile phone/ internet with known and unknown people that includes giving out identifying details.
- Persistent use of 'dirty' words/sex talk.
- Persistently following or spying on people in order to see them naked.

Highly concerning sexual behaviours:

- Compulsive masturbation (causing self-harm) or seeking audience for masturbation; public touching or rubbing to the exclusion of normal childhood activities.
- Forcing other children to play sexual games.
- Having/displaying sexual knowledge too advanced for their age.
- Disclosure of sexual abuse.

- Persistent bullying involving sexual aggression (removing children's clothing, threatening notes or drawings).
- Sexual behaviour with significantly younger or less able children; touching other children without their consent.
- Seeking out opportunities to touch others or engage in sexual activity (accessing other children's bedrooms at night).
- Persistent sexual activity with animals.
- Presence of sexually transmitted infection/urinary tract infections.
- Simulation of sexual activities and explicitly sexual/ adult language
- Using mobile phones/internet to give out identifying details or sexual content.
- Displays persistent interest in pornography.
- Degrading themselves or others using sexual themes.
- Penetration of dolls, children or animals.

Children Aged 13-17 years:

Normal sexual behaviours:

- Need to be private; masturbation occurs in private.
- Curious about and may access information about sexuality, contraception and bodily changes in girls/boys.
- Interest in participating in relationship with other boy/girl.
- Hugging, kissing of peers.
- Occasional flashing of body parts in context of play with peers (exhibitionism, mooning).
- Use of sexual language; sexual humour and obscenities with peers.
- In older adolescents, interest and/or participation in sexual relationship with partner of similar age.
- In older adolescents, interest in viewing materials for sexual arousal (internet, music videos, magazines, movies).
- Use of mobile phones/internet for relationships with known peers.

Concerning sexual behaviours:

- Masturbation in preference to other activities, in public and/or causing self-injury.
- Persistent explicit talk, art or play which is sexual or sexually intimidating.
- Sexual preoccupation which interferes with daily function.
- Intentional spying on others while they are engaged in sexual activity or nudity.
- Engaging in sexual activities with an unknown peer e.g. kissing, mutual masturbation.
- Marked changes to behaviour e.g. flirting with older adult, seeking relationships with older children or adults in preference to peers.
- Using mobile phones and internet with unknown people which may include giving out identifying details or sexual material.
- Accessing age restricted materials e.g. movies, games, internet with sexually explicit content; arranging a meeting with an online acquaintance accompanied by a peer or known adult.
- Explicit communications, art or actions which are obscene or sexually intimidating.
- Repeat exposure of private parts in a public place (e.g., flashing).
- Oral sex and/or intercourse with known partner of more than two years age difference or with significant difference in development.
- In older adolescents, unsafe sexual behaviour, including unprotected sex, sexual activity while intoxicated, multiple partners and/or frequent change of partner.
- Presence of sexually transmitted infection or unplanned pregnancy; persistent expression of fear of sexually transmitted infection or pregnancy.

Highly concerning sexual behaviours:

- Compulsive masturbation, masturbation in public, seeking and audience, self-harm.
- Forcing or coercing others into sexual activity; engaging vulnerable others in grooming for the purpose of sexual activity (providing gifts, flattery, lies, manipulation).
- Sexual activity or sexual contact (oral sex or intercourse) with a person of different age, developmental ability or peer grouping.

- Engaging in sexual activity in return for goods, money, accommodation, drugs or alcohol.
- Engaging in sexual contact with animals.
- Preoccupation with sexually aggressive and/or illegal pornography or similar material.
- Deliberately sending or publishing sexual images of self or others.
- Possessing, accessing or sending child sexual material (photos of naked children or children engaging in sexual activities).
- Presence of sexually transmitted infection or pregnancy.
- Arranging to meet an online acquaintance without the knowledge of a peer or known adult.

Sources: Adapted from DHS (Victoria) (2012): *Children with Problem Sexual Behaviours and their Families: Best Interests Case Practice Model. Specialist Practice Resource and Family Planning Queensland (n.d). Sexual Behaviours in Children and Young People: A Guide to Identify, Understand and Respond to Sexual Behaviours.*

Get Your Child Therapeutic Support at the Right Time

If your child's sexual behaviour is related to past trauma, your child may need therapeutic support at some stage. Children's experience and memory of sexual trauma varies and this can affect their development in different ways.

Very young children can 'act out' their trauma through play with dolls or sand play; or they may be able to express their distress through drawings and stories. But young children may have little ability to verbalise feelings of fear, dread, or guilt. As such, very young children may not be able or willing to talk through memories of trauma and abuse in the same way that older children could.

As children get older; and particularly when they begin puberty; memories and reminders of abuse are more likely to come to the surface. This is particularly likely if they have been unable or unwilling to process trauma memories before then.

Children can 're-visit' trauma at each new milestone of sexual development; for example when they get a boyfriend/girlfriend; become sexually active; or have their first child. Each of these stages can be emotionally difficult for children who have been affected by sexual abuse. At the same time, each transitional stage can offer new opportunities for the child to process and make sense of what has happened to them in the past.

Most children will benefit from receiving therapeutic support from a counsellor at some stage. But the timing is important. Whether or not your child will respond to therapy can depend on how well they remember the abuse; how well they understand; and how they have made sense of it. You will need to make a judgment, together with your child, about when and how therapy can be used.

As part of trauma therapy a child will often be asked to re-experience frightening events; this is in order for the child to be able to re-evaluate these events from the point of view of the 'here and now'. Re-experiencing and re-processing past events allows the child to realise that they are now safe; and that they coped with traumatic events in the best way they knew at the time.

Therapy allows a child to develop a more realistic view of themselves and of the perpetrator. However, therapy can be a very difficult process, so you may find your child's behaviour more difficult to manage during this time. It is important that everyone in the family is prepared to support each other during this time. A therapist should be able to talk to you about what to consider before commencing therapy and when therapy would be most beneficial.

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