

Medical Provider Recommended Guidelines

What Is the Role of the Medical Provider for Children Under 12 with Problematic Sexual Behaviors (YPSB)?

This document is designed to assist the medical provider when a child with problematic sexual behaviors (PSB) presents in the clinic setting. These guidelines are focused on a multidisciplinary team approach with an educational component. There may be times when a provider may not have access to all of the team members and these guidelines will provide some suggested next steps. In addition, the Appendices contain information on normal and abnormal behaviors most frequently seen in children less than 12 years of age as well as discuss when children first begin engaging in sexual relationships. Medical providers should understand that children with PSB are very different from adolescent sex offenders.

It is important that the medical provider understand that they do have a role in working with these children, and it is not solely the role of the mental health provider. These children need a holistic, multidisciplinary approach that focuses on education with both the child and their caregivers as well as providing available resources. It is important that these young children are not treated as perpetrators but instead to focus on the behaviors with redirection rather than punitive outcomes. Remember, children are resilient and teachable.

Definition/Background

Youth with problematic sexual behaviors come from a diverse population of children and adolescents who have, for a variety of reasons, engaged in problematic sexual behavior (Office of Juvenile Justice and Delinquency Prevention (OJJDP), 2018).

Chaffin et al. (2008) state that problematic sexual behaviors refer to actions that children, ages 12 years and younger, engage in that are developmentally inappropriate, involve sexual body parts, and may be harmful to themselves or others. Association for the Treatment of Sexual Abusers Task Force on Children with Sexual Behavior Problems provides guidelines for determining if sexual behavior is problematic. The main issues to consider are: frequency of behavior, developmental factors, and level of harm involved. Mesman, Harper, Edge, Brandt, and Pemberton (2019) provide some guidance, stating that the if behavior is infrequent, then it is not as concerning. Problematic sexual behaviors (PSB) are ones that continue despite parental intervention and monitoring; are

preoccupying to the child; and are difficult to distract the child from engaging in the behavior. Age disparities are concerning as most sexual behaviors occur between children of the same age and between children who know each other well; PSB occurs between children of disparate ages/development. Behaviors that are highly intrusive (including touching, viewing, penetrative acts), i.e., asking others to engage in sex acts, behaviors that involve aggression, coercion, threats, force and/or intimidation or behaviors that result in physical injury, harm or pain are also considered PSB. These are non-consensual acts.

Research suggests that youth commit more than one-quarter (25.8 percent) of all sex offenses and more than one-third (35.6 percent) of sex offenses against juvenile victims. In addition, studies have found that most youth who sexually offend come to the attention of law enforcement when they are between the ages of 12 and 14 and that early adolescence is the peak age for sexual offenses against younger children. In cases where youth offend against juvenile victims, 88 percent of these victims are reported to be either family members or acquaintances (OJJDP, 2018). Data gathered from OJJDP show that 38 percent of children younger than 6 years of age, 42 percent of children age 6-11 years, and 31 percent of children 12-17 years of age were sexually victimized by another juvenile (OJJDP, 2018). In addition, 15 percent of children under 6 years of age and 12 percent of children age 6-11 were victimized by children under the age of 12 years (OJJDP, 2018). A significant number of children who present with PSB have a past history of physical abuse, are raised in homes with poor family boundaries, and are exposed to potential sexual activity, sexual images/material and/or nudity in the home (Mesman et al., 2019). Other predictive factors for children with problematic sexual behaviors include poverty, single parent households, and poor parenting practices (Mesman et al., 2019).

Presentation to the Clinic

Children that exhibit PSB come from diverse backgrounds. Boys are more likely to be the ones displaying PSB (Mesman et al., 2019), and it is important to remember that as the age of the child increases so does the aggressiveness of the acts. Children with PSB are more likely to have the following additional diagnoses: oppositional behaviors, conduct problems, hyperactivity and impulsivity, social difficulties, inattention, complex trauma history, and/or severe trauma symptoms (Mesman et al., 2019). In addition, these children frequently have a prior history of sexual abuse; however, it is important to remember that most children who are sexually abused do not have PSB (only 35 percent of preschoolers and 6 percent of school aged children) (Mesman et al., 2019).

Role of the Medical Provider

The medical provider's focus should be on the child and working with the parents and child to address the behaviors and resources. As the medical provider, it is important to define the behavior, not the child; remember behavior is fixable, children are resilient. Determine if the behavior is self-focused or involves other children (Chaffin et al., 2008). While it is not the primary role of the medical provider to assess home safety, it is important to assess if the parent/caregiver is receptive to information regarding the range of normal versus problematic sexual behaviors. This is especially important when the sexual exploration/contact is occurring between children living in the same home. While it is important for a caregiver to not over-react to normal sexual behavior, it is equally important that they not dismiss concerns about providing appropriate supervision/safety planning when the activity that is occurring is intrusive, coercive or aggressive.

The evaluation should consist of a comprehensive, holistic assessment, including a multidisciplinary approach. Your role as the medical provider is to conduct a thorough medical evaluation and work as part of the multidisciplinary team. If a child with PSP presents to the clinic, ascertain if the child is currently in a safe environment where they are supported and if not, what actions are necessary to create a safe environment for them (e.g., referrals, mandated reporting if abuse is reported to you). Determine if outpatient community-based interventions are warranted and what resources are available that best fit the needs of the child and their family when making referrals.

Other team members may be involved through efforts such as conducting a forensic interview and conducting a thorough trauma assessment to screen for trauma and risk factors. Assessing for exposure to online chat rooms or pornography, and providing education to both the child, family and community may be warranted. These activities do not all need to be done in the office.

It is important to note that the most effective treatments of PSB include a focus on parenting and behavior management. Cognitive behavioral therapy (CBT) has been shown to be extremely effective with these children. Structured CBT focusing on behavior management and psychoeducation yield positive results and is predictive of lasting treatment effects (Mesman et al., 2019); therefore, making referrals to the appropriate mental health providers is essential.

In addition, medical providers need to understand typical child sexual development, the differences between age-appropriate sexual behaviors and problematic sexual behaviors (PSB) and be able to offer appropriate guidance and/or treatment recommendations (Mesman et al., 2019; Chaffin et al., 2008). Your role as the medical provider includes a strong education component regarding normal child sexual development that can be delivered in a factual way to dispel any myths or misinformation.

Normal childhood sexual play and exploration “is behavior that occurs spontaneously, intermittently, is mutual and non-coercive when it involves other children, and the behavior itself does not cause emotional distress” (Chaffin et al., 2008, p. 3). The play is not a preoccupation. It does not involve advanced sexual behaviors (intercourse or oral sex). It is normal to have some degree of curiosity in sexual behavior and in sexual stimulation (Chaffin et al., 2008). Medical providers should inform parents that, as a medical provider, they are mandated reporters and that they work with the multidisciplinary team (National Center on the Sexual Behavior of Youth, n.d.). Remember to let caregivers know that not all information is kept confidential and may be shared with the MDT (National Center on the Sexual Behavior of Youth, n.d.). See Appendix A for normal and concerning behaviors.

Recommendations

As a medical provider, you can provide education to parents about normative behaviors in children as well as normal sexual development as you try and sort out normal from concerning behaviors. It is important to be familiar with the literature so that the information you convey is accurate.

Education can include the fact that children are curious about sex throughout their childhood. Studies show that preschool children exhibit many sexual behaviors; as they grow older, they tend to become more inhibited as they understand the social contexts of acceptable behaviors, so the behaviors may appear to decrease (e.g., masturbating in public) while other behaviors increase (sex talk, trying to look at nude people, self-stimulation, and games of trying to show genitals) (Vosmer, Hackett, & Callanan, 2009; Poole & Wolfe, 2009). It is important to remember that boys tend to engage in more sexual behaviors than girls and at a great frequency throughout childhood (Vosmer et al., 2009).

Normal sexual behaviors in children under 12 years of age can be consensual, exploratory, and periodic; they may occur between children who know each other well and are approximately the

same age (Mesman et al., 2019). During adolescence, sexual behavior becomes normative; oral sex is now a frequent precursor to vaginal sex (Poole & Wolfe, 2009). For more data on when adolescents are becoming sexually active and what types of sexual acts they are participating in, see Appendix B.

Beyond the thorough medical history, exam, and education, appropriate referrals are important as well as working with the multidisciplinary team to ensure that the child and their family receive the resources and assistance that they need to resolve the PSB.

Take Home Points

- Problematic sexual behaviors involve coercion, are highly intrusive, preoccupying, occur in children of disparate ages/development, occur with frequency, and may be planned versus spontaneous (Mesman et al., 2019, Chaffin et al., 2008).
- Concerning behaviors (rarely seen) include: trying to have sexual intercourse (including oral, vaginal, and anal); putting mouths on sexual body parts belonging to others; asking others to engage in sexual acts; and inserting objects or digits into the rectum/vagina (Mesman et al., 2019).
- CACs should also be educated about these children. CACs can have the family and child sign onto the home safety plan developed by the National Children's Alliance (n.d.).
- As the medical provider, you should obtain information regarding the frequency of the problematic behavior(s) and assist with parent management.
- Ask parents how often the child engages in this behavior and what may help in eliminating the behavior (Mesman et al., 2019).
- Consider developmental factors. Determine the age of the children involved in the sexual behavior, if the behavior is normal for the child's age range, and assess if the child's social functioning is adversely impacted by the behavior (Mesman et al., 2019).
- Assess level of harm. When obtaining the medical history, ask about dynamics of play, emotions involved or elicited, and whether physical harm has occurred (Mesman et al., 2019).
- Assess home environment by inquiring about who is home with the child, who the caregivers are, and if there are any perceived risk factors.
- Ask if the child has a past history of sexual abuse.
- Discuss names and functions of body parts with child.
- Provide education about normal sexual behaviors.

- If the child is not working with a psychologist, as a medical provider you can provide social rules and guidance regarding sexuality.
- Make referrals to mental health, as needed, for both child and family. Consider siblings in the household in addition to parents.
- Report to authorities in cases of suspected abuse, if not already reported. Remember, as a medical provider, you are a mandated reporter.
- Provide reassurance.
- Work with the parents and educator (if available) to provide sex education that is developmentally appropriate. Remember, pregnancy education should be an important component for both adolescent boys and girls.
- Educate parents about redirecting child's inappropriate behaviors and praising them for following the directive.
- Inform the MDT if a parent is dismissive of concerns of providing appropriate supervision/safety plan when discussing PSBs that are intrusive, coercive or aggressive that have occurred in the home, and/or resistant to referral for appropriate behavioral therapy resources.

Appendix A: Normal and Concerning Behaviors

Normal Behaviors

Young children (toddler and preschool; early school age)

- Masturbation
- Touching own genitals (behavior decreases with age)
- Touching mother's breasts (behavior decreases with age)
- Showing genitals to other children or adults (behavior decreases with age)

Older children (school age to early adolescence)

- Masturbation (may become more sophisticated)
- Showing interest in the opposite sex
- Asking questions about sex
- Looking at nude photos
- Drawing sexual parts
- Talking about sex
- Using sexual words
- Sex play (touching and/or looking at genitals) between age mates (less than 4 years age difference) without concerning factors (force, bribe, threat, etc.)

Concerning Behaviors

- Sexual behaviors that cause concern
- Repeated object insertion into vagina and/or anus
- Age-inappropriate knowledge of sex; for example, knowing how pieces and parts fit together for oral sex, anal sex, or intercourse
- Child asking to be touched/kissed/etc. in genital area
- Sex play involving one or more of the following:
 - Oral-genital contact
 - Anal-genital contact
 - Genital-genital contact
 - Digital penetration of vagina/anus
 - Object penetration of vagina/anus
 - Four years or greater age difference between children
 - Use of force, threat, or bribe
- Common sexual behavior in childhood with features that cause concern
 - Increased frequency of the behavior
 - Unable to redirect child from the behavior
 - Child's demeanor while exhibiting the behavior
 - Child's talk accompanying the behavior

(Davies, Glaser, & Kossoff, 2000; Gil, 1993; and Heiman, Leiblum, Esquelin, & Pallitto, 1998; as cited in Hornor, 2004)

Appendix B: Onset of Sexual Activity

It should be noted that increasingly teens are becoming sexually active at an earlier age and oral sex is now a frequent precursor to vaginal sex (Poole & Wolfe, 2009).

In one research study, they looked at 50 studies with 87,334 adolescents with a mean age 15.10 overall. Seventeen of the studies included exclusively teens from the United States. Teens with an early pubertal timing were more likely to engage in their first sexual experience at a younger age. (Baams, Semon Dubas, Overbeek, & van Aken, 2015).

In another study of 580 ninth graders conducted by the Guttmacher Institute, the average age for engaging in sexual acts was 14.5 years, with 20 percent of the teens saying they had had oral sex, which was significantly more than those who reported vaginal intercourse (14 percent). Explanations for this included: less chance of becoming pregnant or contracting sexually transmitted infections; it would not ruin their reputation; and they would not get into trouble or feel guilty. There is a greater acceptance of oral sex than of vaginal intercourse (Hollander, 2005).

During adolescence, sexual behavior becomes normative. Among young men in high school, reports of vaginal-penile intercourse increase from 38.1 percent of 9th grade boys to 62.8 percent of 12th grade boys (Ott, 2010). These estimates are consistent with the 2002 National Survey of Family Growth (NSFG), which found that 49 percent of males 15 to 19 years of age reported vaginal-penile intercourse (Ott, 2010). Other sexual behaviors were also common, as 55 percent of these 15 to 19-year olds reported oral intercourse, and 11 percent reported anal intercourse (Ott, 2010).

Among high-risk populations of young men, such as those involved with the juvenile justice system or attending STI clinics, the proportion who are sexually active is higher and the age of sexual onset is lower (Ott, 2010). While not all sexual behavior in adolescent males is problematic, a young age of onset represents an increased risk for sexual coercion, STIs, and early fatherhood (Ott, 2010)

Finally, Jordahl and Lohman (2009) looked at the onset of oral sexual activity amongst youth and divided it into four waves starting in 1994-1995 all the way to 2008. They found that for females, early onset of sexual activity began at age 10-15 (20.8 percent); normative at 16-20 (60.9 percent); and late at 20+ years (14.3 percent). For males, early onset of sexual activity began at 10-14 years (16.9 percent); normative at 15-19 years (65.6 percent); and late at 19+ years (14.9 percent). Only 4.1 percent of females and 2.7 percent of males reported no oral sex experience. So even with starting in the 1990's, the percentages of oral sex of 10-14/15-year olds is not insignificant (Jordahl & Lohman, 2009).

Percentage of U.S. adolescents who reported selected romantic and sexual events, by race and ethnicity of couple				
Event	Both white (N=3,771)	Both black (N=1,265)	Both Asian (N=221)	Both Hispanic (N=881)
Romantic†	69.8	65.9	68.0	71.9
Sexual	66.0**	71.5**	53.0**	56.5**
Touched partner under/without clothes	63.5	63.6	50.8	50.2
Touched partner's genitals	57.9	55.3	45.3	45.2
Had sexual intercourse	41.5	56.8	31.6	42.7

**Significantly different from proportion reporting romantic events at $p < .01$. †Declared love for each other, held partner's hand and kissed partner plus one of the following: told others they and their partner were a couple, thought of themselves and their partner as a couple or exchanged gifts.

(O'Sullivan, Mantsum, Harris, & Brooks-Gunn, 2007)

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Additional Reading

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