Part 1.
Talking with children about sex

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Paediatricians can do it

<u>Paediatricians are</u>

At ease with children / Use a child-friendly manner

Familiar with children's language & meaning

- Strange Language : Child Victims under Cross Examination Brennan & Brennan 1989 (ncjrs)

Informed about

child development

anatomy / use correct terms

child behaviour (normal & abnormal)

Competent at interviewing multiple sources to gather info

Ethical. We desire to do good, not harm

Primum non nocere

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Do

- Gauge and respect child's developmental level, emotional state and willingness (or not) to talk
- Preserve innocence and naivety
- Respect child's family and cultural values
- Respect parental rights and feelings
- Remain mindful of roles of police and child protection
  - Police interview first (whenever possible)

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Don't

- Introduce words beyond the child's common use & understanding for "private parts"
- Corrupt children with your (new) ideas or suggest scenarios/behaviours
- Lead with "yes/no questions"
- Fail to consider alternative possibilities
- Over-interpret words or behaviour with a "confirmatory bias". Many words and behaviours are non-specific, so treat them as such

Be open minded

Enter each consultation willing to explore a range of possible outcomes

Gather data & information THEN process it

Remain open to new, challenging and conflicting ideas throughout

Be prepared to change your mind, always

Avoid bias (learn about bias, act to minimise it)

Seek the truth

The truth might not be “a disclosure”

- So don’t aim for “disclosure” as the sole outcome

A “disclosure” might not be the truth

- So seek confirmation / challenge it

Ask, “what if….?”

- Misinterpreted by an adult
  (child’s comment / art / behaviour)
- Misunderstood / misconstrued by child (no abuse occurred)
- Mistake (no abuse intended but contact occurred)
- Mischief (e.g. ideas implanted by other)
- Malice (e.g. fabricated by child)

Rely on data not dogma

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Where is the data?
How solid is it?

Where is the dogma?
Why did it develop?

Be a team player

Respect roles and responsibilities

Understand the system and the players interactions with each other (not just you)

Police interview (VARE) before medical exam

Aim to minimise duplication & maximise efficiency

Be reliable and dependable

Do your job well (quality and safety)

Act & Speak up / Advocate for child & system

Be honest

Don’t overinflate expectations of justice or a particular outcome

Don’t make promises you might not keep

Consent: ensure it is fully informed

If in doubt, don’t

(+ ASK/CONSULT)

Own all your errors!

Speak up when something or someone is wrong

“the available information and findings do not discriminate between children who have been sexually assaulted and those who have not”

Before you talk with a child

- Understand developmental pathways
  - Cognition and general behaviour
  - Sexualised behaviour
- Gather information from others
  - Caregivers
  - Police & child protection
- Plan how you will proceed in this case
  - Not one size fits all

Adapt approach to child

Be flexible – child's emotions, attitude and tiredness will affect the interaction. Document observations.

Unwilling child - > abandon the interview.

This means STOP

Adapt to developmental level

Words per sentence = age in years

Separating child from parent can help but also can hinder the interview process

(Generally younger children prefer their parents present, older children prefer parents NOT to be present)

Child's choice of support person throughout (NB can change mind midway through, and repeatedly)

How do I start the conversation?

Introduce yourself

- Explain who you are & what you do

Possible conversation starters

- Why did you come here today?
- Parents might offer to 'explain' the reason
- Mum said that something happened on the weekend with your cousin Bart and my job is to .... so that we can see if we need to do something about it
- XXX said that you said something about YYY and it made ZZZ worried.
- My job is to talk with you and have a look at you to try and understand what might be going on ... (and I will probably tell the police about what we talk about)

How do I start taking about sex?

Some children will promptly talk about the alleged abuse.
Others will need prompts.
Don't interrogate.

Before we start, can I ask what words you use for the bits of the body that are usually covered up by **bathers**/swimsuit/underwear? Parents might need to volunteer words when children are "shy"

Is it all right if I write down your words on this picture so I get it right and don't forget?

And what about boys/girls? (other gender)
What parts of their bodies are under their bathers?
What do you call those bits?
What words do you use in your family for those bits?

Good touches/Bad touches

Not everyone uses this approach

It requires an understanding of the interview process and capacity to manage children's information

It is important to record children's comments verbatim

Questions:

I want to talk with you about the sorts of touches that people give and get from each other

Some touches feel really nice and we feel good about them, some touches feel "not nice" and can make us feel hurt or sad or mixed up or they just don't seem right somehow.

Has anyone given you any good touches?

- Any others?

Has anyone given you any "not good" or "bad touches"?

- Any others?

“Private parts”

Remember that we talked about your genitals/anus/chest (use child’s terms) before. The bits of the body under your bathers. Some people call them “private parts”

Who is allowed to look at them (or use child’s term)?

(Reassure that ok for child to look, and Mum/Dad… if sore and child wants them to check, or a doctor if Mum/Dad and child agree and they are with child)

Has anyone who is not allowed to, looked at them?

“Private parts”

Who is allowed to touch them?

(Reassure that child can touch, and Mum/Dad if sore and need to apply cream…, doctor…)

Has anyone who is not allowed to, touched them?

What would you do if someone tried to look at or touch them?

(“Stop, I don’t like it”, and tell teacher/parent etc.)

Finish with, e.g. “Thank you for talking with me about this. Your body belongs to you and you decide if you want anyone to look at it or touch it”

Secrets: Good and Bad

Most children your age have secrets of some sort

Some secrets are good ones & we feel good about them, some secrets are not good ones, they feel "not nice" and can make us feel worried or sad or mixed up or they just don't seem right somehow.

Do you have any good secrets? Who else knows?

Any others?

How about the other sort? The "not good" or bad secrets. Do you have any secrets that make you feel bad? Who else knows?

Any others?

Conversation enhancers

And then what?

Ah huh, pause……

Tell me more about that…

Can I check that I understood that correctly, did you say …. (reflective listening)

When you say “his thing” do you mean his… Pause… “

Conversation stoppers

Avoid “did he /she …. ” questions

Never suggest a behaviour

- e.g.“Did he put his thing in your …
- e.g. “did anything go in your …. “ “did anything come out of his ….”

Never suggest a particular individual (by name or relationship) unless and until mentioned by the child

Don’t ask

Anything about pain unless the child says it first then you can ask about what it felt like and how long it lasted etc.

- Most child sexual abuse doesn’t physically hurt the genitals. (Most abusers are known to the child and want to come back for more)

Don’t ask “Did it hurt?”

- This could insert a worrying idea into a child’s head
- If it felt pleasurable then the psychological damage could be worse if you created the idea that it “should” have hurt, not felt nice

Don’t ask

Anything about blood, bleeding or discharge unless child introduces the idea

Anything about emissions, seminal fluid or other body fluids unless child introduces the idea

Refer to the abuser’s behaviour as “naughty” or “bad”; perhaps use the term “wrong”

“No comment” is recommended

Do ask

<u>But only if relevant</u>

What did that feel like?

Genital sensation/ touch

How did that make you feel?

Emotional feelings

And when you did wee after that, how did that feel?

Did you notice anything else? Did anything else happen?

Did he/she say anything about you telling anyone else about what happened?

-> Did he/she what would happen if you told anyone else about what happened?

Keep your emotions in check

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Professionalism at all times

No unseemly over-interest or harping on about something when child is uncomfortable

No repeated questioning - same idea/topic

No gasps and horror/ shock & squirm

No tears and sobs (from you)

No impatience

No visible signs of your disbelief

Offer to answer questions

Offer to answer any questions the child may have

Answer honestly

Clarify what will happen next in relation to your roles & the investigation more broadly

Offer again “is there anything else that I can do for you today?”

Positive comments

"Your body is really healthy and strong. Your bottom (+ child's word for genitals) look exactly right for a girl/boy your age"

"No-one will ever know by looking or by touching, what happened to you (+ other words) – the only way anyone will ever know is if you tell them"

Explain to older children that usually it is best to tell only people they can really trust because they don't want everyone at school knowing

Quit patronising

Respectful courtesy is best

- “I could see that you found it really hard to talk about some of the things that happened”.
- Thankyou for telling me about … even when it made you feel really upset/cry to talk about it.
- I didn’t want to upset you but I did want to understand what happened so I could work out how best to help you.

“You were so brave” statements can seem hollow, trite and fake so if they aren’t genuine & appropriate statements of fact, don’t say them.

Finish with optimism

Thankyou for talking with me today.

Now that we know what happened … Mum and Dad and all the people you have met this week will do everything we can to make things better for you and to make sure it doesn't happen again. The police and I, and everyone else, will get on with our jobs to help you. We want things like (what we talked about) to stop so you can just enjoy being a happy girl/boy.

I am very happy to see you again if you want to.

Part 2. Sexualised Behaviour

What is it and how might I interpret it?

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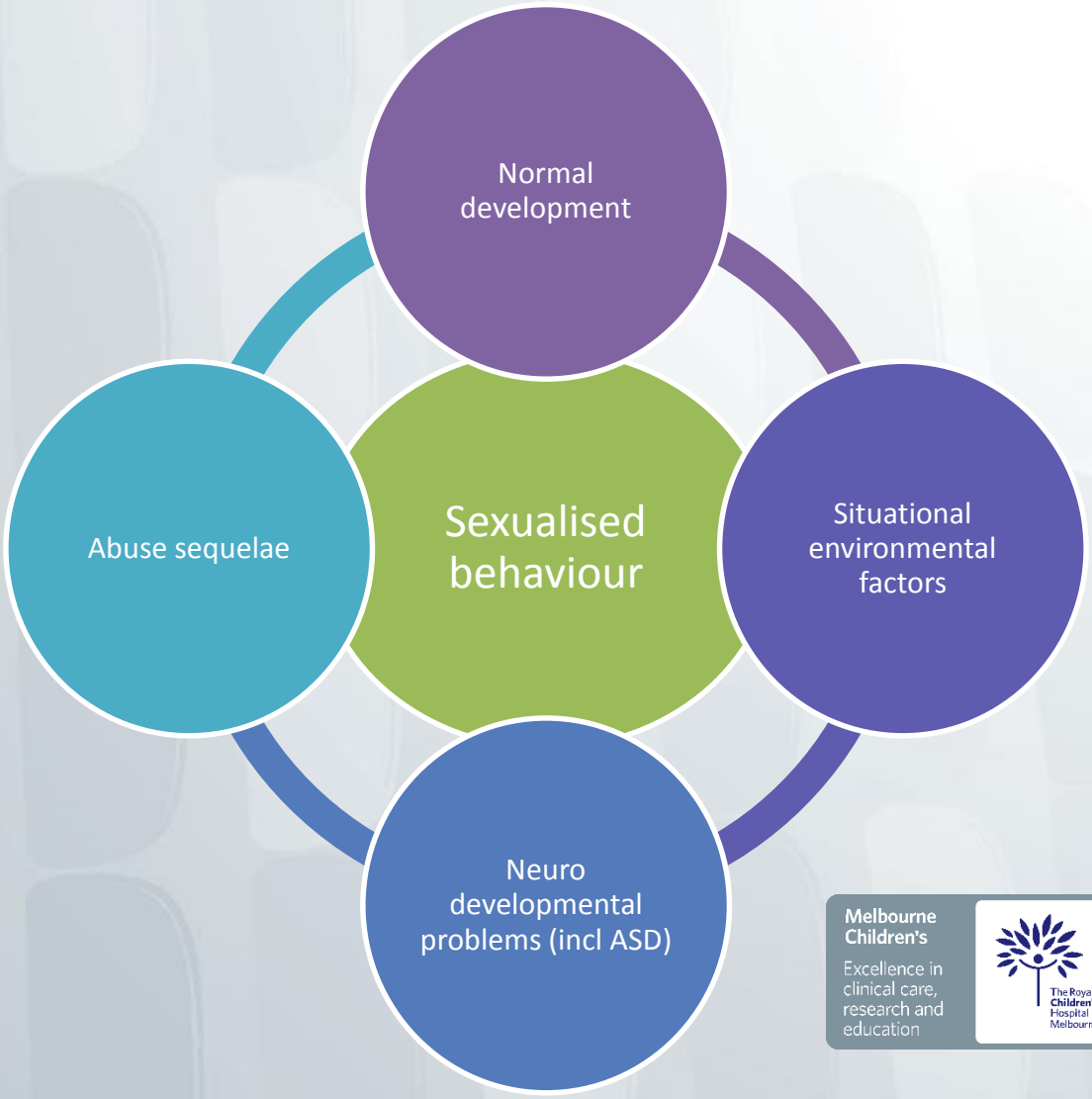
With thanks to Prof Dawn Elder (Otago University) for developmental framework

Sexualised behaviour: 4 key associations



What IS sexualised behaviour?

- How is it defined?
  - THERE IS NO ACCEPTED DEFINITION

  (Something to do with bottoms and/or sex)
- What is the context?
- Are there age appropriate norms?
- Are there cultural norms?
- Who “diagnoses” it?

- How is it evaluated?

What is “normal” sexual behaviour?

Be mindful of:

- Sensuality (touch = a nice feeling)
- Curiosity
- Experimentation / exploration
- Awareness of sexuality (~ cognitive development)
- Relationship building (skills to manage)
- Pathway towards increasing intimacy

- Varying views: Beware ‘pathologising’ or ‘attributing motives’

What is “abnormal” sexual behaviour?

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Be mindful of:

- Own and other’s values and bias
- Own and other’s knowledge base
  - “soft” literature / weak evidence
  - BEHAVIOUR “PROFILE” CANNOT DIAGNOSE SEXUAL ABUSE
- Other’s observations
  - INTERPRETATION by others (observer ascribes motive)
  - Mistaken / misinterpretation
  - Fabrication /false report
- Other’s interpretation of child’s comment
- Range of atypical behaviours in children with developmental problems, poor impulse control, low empathy.....

How do we assess sexualised behaviour?

What information forms the BASIS for concern?

Occasionally we observe behaviour

Usually it is a story

- Sometimes it is described by child/adolescent him/herself
  - "I do this…"
- Often reports of witnessed behaviour (by 3rd person)
  - "I saw /heard him/her do this…"
- Sometimes "chinese whispers"
  - Someone else said they saw.. heard…. felt…him/her do this….

Beware POTENTIAL ERROR AND BIAS when relying on others' interpretations of reported or observed behaviour

Documentation

We must identify

- ALL Sources of information
- Details: What is the problem?
- Circumstances : The 5 W and H

Then COLLATE information

ONLY THEN can we start to hypothesise about possible causes (“interpret the behaviour”)

Hypothesis testing Developmental framework

Questions: within a developmental framework

- Is this common behaviour for a child of this age?
- Is this behaviour uncommon but within the age appropriate range?
- Is this behaviour commonly seen in children of a different age?
- Is this behaviour uncommonly seen in children of any age?

Normal, common behaviors	Less common normal behaviors[a]	Uncommon behaviors in normal children[b]	Rarely normal[c]
Touching masturbating genitals in public/private Viewing/touching peer or new sibling genitals Showing genitals to peers Standing/sitting too close Tries to view peer/adult nudity Behaviors are transient, few, and distractible	Rubbing body against others Trying to insert tongue in mouth while kissing Touching peer/adult genitals Crude mimic of movements associated with sexual acts Sexual behaviors that are occasionally, but persistently, disruptive to others Behaviors are transient and moderately responsive to distraction	Asking peer/adult to engage in specific sexual act(s) Inserting objects into genitals Explicit imitation of intercourse Touching animal genitals Sexual behaviors that are frequently disruptive to others Behaviors are persistent and resistant to parental distraction	Any sexual behaviors involving 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 Behaviors are persistent and child becomes angry if distracted

http://www.aap.org/pubserv/PSVpreview/pages/behaviorchart.html

Hypothesis testing
Forensic framework

Questions: within a forensic framework

- Is this common behaviour for a child of this age?
- Is this behaviour commonly seen in subgroup of children of a different age?
- Is this behaviour commonly seen in a subgroup of children with a known condition?: Eg
  - children who have ID?
  - children who have ASD?
  - children who have ADHD?
  - children who are mentally ill?
  - sexually abused children?
  - little criminals in the making?
- Is this behaviour uncommonly seen in children of any age? If so, I wonder why this child....?

Common sexualised behaviours (all children)

- Looking
  - Sneaking a glance / surreptitious
  - “you show me yours and I’ll show you mine…
- Touching
- Extended touch – rubbing, inserting
- Copying witnessed behaviour (including media)
- Comforting / Arousing self
- Arousing others

Normal Sexual Development 0-2 years

- Capacity for male erection / female lubrication / orgasm
- Immodest
- Genital self-exploration and stimulation: boys moreso
- Insertion of objects into orifices
- Learn & name body parts
  - Vulva: birdie, bum, couchie, fanny, gina, minnie, pee pee, penis, private part, tuktuk, vagina
  - Penis: birdie, bum, dick,doodle, noodle, pee pee, penis, pipi, private part,wee wee, winkie
- Many terms shared between genders
- One term often used for both genitals and anus
  - Encourage parents to name body parts

Normal Sexual Development 3 and 4 years

- Know own gender, talk about gender differences
- Curious
  - Try to touch mother's or other women's breast, or poke at/make fun of father's penis
  - Incessant talk of "boobies"
- Girls may attempt to urinate standing up
- Genital self-exploration and stimulation increases, less sporadic, better motor control
  - Masturbation - males 55%, females 16%
- Disinhibited - "rudie nudie", enjoy being naked

- "Doctors and Nurse "Mothers and Fathers"
- Games involve undressing and sexual exploration
- Exhibitionistic and voyeuristic activities with children/adults
- Interested in people undressing, and other people's genitals
- Copy adult behaviour – kiss, hold hands
- "naughty and rude words"
  - "bum"

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Normal Sexual Development 5-9 years

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5-6 years

- Familiar with gender differences, still asking questions
- Mutual investigation of body parts (usually in private)
- Masturbation - more likely to be private
- More likely to be modest - may demand privacy when changing/in bathroom
- Quickly respond to redirection from sexual play
- More sexual language used (toilet humour and awareness of some sexual behaviours)

6-9 years

- Still asking questions about sex differences / functions / sexuality
- More modest - stop exploratory games, shy about undressing
- Like to hear / tell 'dirty jokes' / words
- Attraction to others / May have school "sweetheart"
- Touch own genitals in private
- 20% still display common preschool behaviours

Normal Sexual Development 9-12 years +

9-12 years

- Mostly very modest, but some alternating disinhibition / inhibition
- Sexual curiosity / preoccupation (>25%)
- Look at pictures of nude people
- Talk about sexual acts
- Peer group dominates interests
- “best friend” common
- Majority of children have a “sweetheart” – sexual experimentation, romantic interest
- Puberty begins

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Most adolescents in Yea are sexually active.

About one in four Year 10, half of all Year 12 students have had vaginal intercourse.

Of the young people who had ever had sex, about half of the males and 61% of the females had at least one sexual partner in the last year.

Between 15% and 19% had two sexual partners in the last year.

37.3% of Year 10 students and 56.7% of Year 12 students have engaged in oral sex.

2002 third *National Survey of Australian Secondary Students, HIV/AIDS and Sexual Health*,

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Adults' recall of childhood sexual behaviour

Ryan 2000, Early Childhood Experience survey (Kempe Centre),

By 12 years:

- 70% sexual arousal,
- 50% ejaculation/orgasm
- Half reported 'sexual' activities with other children (mostly friends) 2/3 fantasy play, ¾ never caught, if caught ½ punished
- < 5% reported more intrusive interactions, eg. penetration or oralgenital contact

More retrospective studies

339 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,
- 5% recalled inserting an object in the vagina or rectum of another child.

Female undergraduates

- 26% recalled exposing themselves,
- 17% recalled unclothed genital touching,
- 4% recalled oral-genital contact during childhood.
- Playing doctor, exposure, stimulation, kissing, “being married”
- 30% reported some coercion or manipulation during cross-gender play

Johnson TC. *Understanding Children's Sexual Behaviors: What's Natural and Healthy*. San Diego, CA: Institute on Violence, Abuse and Trauma; 2007

Lamb S, Coakley M. "Normal" childhood sexual play: games differentiating play from abuse. Child Abuse Negl. 1993;17 (4):515 –526

Uncommon sexual behaviours

- Oral contact with another child's or adult's sexual parts
- Putting tongue in mouth when kissing
- Touching animal genitalia
- Putting objects in own or other child's vagina or rectum
- Touching the genitals of adult women
- Trying to make an adult touch the child's genitals
- Trying to undress other children
- Imitating sexual intercourse with dolls
- Initiating sexual games with other children
- Masturbating excessively or without pleasure or to cause pain

Schoentjes et al Pediatrics 1999 (917, 2-12yo)
Larsson & Svedin Acta Paediatr 2001 (231, 3-6yo)

Factors ~ Sexualised Behaviours

Family sexuality and attitudes toward nudity
- Environments where sexuality more open

Exposure to sexual acts or materials

Extent of supervision

Stressors, including violence, parental absence because of incarceration, death, or illness, family dysfunction

Situations: trigger curiosity eg observe breast feeding

Abuse (sexual abuse AND physical abuse & neglect)

Comorbid diagnoses and developmental delay

Problematic sexual behaviour

Is clearly beyond the child's developmental stage (for example, a three-year-old attempting to kiss an adult's genitals)

Involves threats, force, or aggression

Involves children of widely different ages or abilities (such as 12-year-old "playing doctor" with a four-year-old)

Provokes strong emotional reactions in the child such as anger or anxiety

REGARDLESS OF INTENT / MOTIVE

Sexual behaviours - associated factors

- Age - peak at 5 years
- Maternal education, parental guidance, cultural/religious values
- Family sexuality – attitudes to nudity, adult sexual behaviour
- Family stress, violence, parental separation/divorce
- Physical abuse, neglect, sexual abuse
- Exposure to adult TV, videos, magazines
- Time in child care, influence of other children, peer group
- Developmental delay
- Other child emotional or behavioural problems

Friedrich et al Pediatrics 1998
Schoentjes et al Pediatrics 1999
Larrson & Svedin 2001

Sexual Behaviour Continuum: A theory

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Group I: Normal Sexual Exploration

- Might engage in Problematic SB
- Curious, lighthearted, spontaneous

Group II: Sexually Reactive

- Sexual curiosity/focus/stimulation more pronounced/compulsive than peers.
- May feel anxious, shame, guilt
- Usually self-focused, more so than with other children
- +/- past sexual experiences – sexual abuse, pornography, TV, sex

Cavanagh Johnson

Group III: Extensive Mutl Behaviours

- More pervasive/focused sexual behaviour pattern.
- Use persuasion, not force
- Blasé/matter-of-fact attitude.
- Often in care
- Often emotionally, sexually, physically abused +/or dysfunctional homes

Group IV: Children Who Sexually abuse others

- Pervasive/consistent/compulsive/aggressive/coercive pattern
- Angry, lack empathy, lonely, fearful
- Extensive behavioural problems, poor schoolwork, no friends
- Most sexually abused, emotionally abused, received severe punishment

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Problematic Sexual Behaviour: Also a continuum

- "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".

- "This association suggests that some sexual behaviors occur within a continuum of behavioral problems with multifactorial causes".

Friedrich WN, Fisher J, Broughton D, Houston M, Shafran CR. Normative sexual behavior in children: a contemporary sample. *Pediatrics.* 1998;101 (4).

What are the risks to the child with problematic SB?

- Gratification / Reward –> entrenched behaviours
- Important relationships suffer
- Social ostracism
- Self esteem / self concept affected
- (Mis)interpretation by others of motive
  - “offender” = criminal status
  - Egocentric => no empathy => sociopathic? PD?
  - Mentally ill ? “labelled”
  - Developmentally delayed or deviant?
  - Post traumatic? Sequelae of abuse? Ie VICTIM.. Therefore someone guilty of offence of sexual abuse.. WHO?

Differing constructs & paradigms

- Rights: Human rights and Child rights
- Behavioural developmental perspective of child behaviour
- Health focus (epidemiology and evidence based intervention)
- Forensic medicine : impartial assessment of “evidence”
- Ethics: good outcomes / harm minimalisation

- Child protection – question possibility of victimisation/ assault others

- Centres Against Sexual Assault
  - Feminist ideology
  - Advocacy = VICTIM
  - Counselling to reduce long term psychological harm to victim

- Criminal justice system: the *Crimes Act 1958.*
  - Proof: an offence occurred!
  - Justice for VICTIM
  - Punish OFFENDER
  - Safeguard community

Therapeutic Treatment Orders

- Children Youth and Families Act 2005. (Vic Statute)
- 10-14 year olds
- *"intervening early with children and young people exhibiting sexually abusive behaviour can help to prevent ongoing and more serious sexual offences".*
- Child Protection apply to Children's Court for order
- Therapeutic Treatment Board.
  - Child Protection, Victoria Police, the Office for Public Prosecutions and treatment providers (CASA)
  - Advisory
  - Final decisions on whether to pursue criminal justice and protective actions will remain with the Director of Public Prosecutions and the Secretary respectively.

- NO PAEDIATRIC HEALTH ADVISORS.

Sexual behaviours in sexually abused children

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Developmentally expected sexual behaviour

Unplanned, interpersonal sexual behaviour

Self-focused sexual behaviour

Planned interpersonal sexual behaviour

Planned coercive interpersonal sexual behaviour

Hall et al Child Abuse & Neglect 2002 (100, 3-7yo)

Sexualised Behaviours in children with Autism

MOST are "normal behaviours" exhibited in wrong place, wrong time, wrong amount

- Self comforting
- Self stimulatory
- Treat people as objects – touch / tactile
- Persist despite resistance/limit setting

SOME are consequence of sexual exposure/ experiences (ie abuse/assault)

- Eroticised
- Maladaptive learned patterns of behaviour
- Reaction to trauma

All = Less responsive to limit-setting, Behav mod techniques and CBT

Sexual behaviours in Children with ASD

Same drives, interests, experimentation as other children

SB can be the “problem behaviour” that leads to diagnosis of ASD (note risk of circular reasoning)

Failure to discriminate “private” vs “public”

Acceptable behaviour at younger age or different context

Failure to consider the matter of consent!

What are the triggers? (Boredom? Anxiety? Pleasure? Obsession?...)

What are the risks to children with ASD and SB?

Misinterpretation of motive (cause) for behaviour

- Could the behaviour be caused by abuse?
  (involve statutory authorities, remove child from carers, charge alleged offender…)
- Could the behaviour be caused by autism?
  (fail to detect abuse, child continues to be abused)

Misunderstanding of child's emotional needs

Failure to identify drivers / triggers

Incorrect/ineffective management & intervention

NB EVALUATION REQUIRES KNOWLEDGE OF CHILD DEVELOPMENT, ASD, CSA AND SB

Autism and Child Sexual Abuse

17% all girls and 7% all boys = unwanted sex by 16 yr

Most children with autism and sexualised behaviours have NOT been sexually abused

Children with autism can be sexually abused

- Children with autism are vulnerable to sexual exploitation

Children with autism can abuse/assault others

Sexualised behaviours do not provide basis for diagnosis of sexual abuse

Children with autism, CSA and sexualised behaviours can be challenging to manage

- (aim = to reduce SB)

Intellectual disability and CSA

Both groups

- More vulnerable to abuse
- More likely to engage in “abusive” behaviours

Behaviours more commonly seen in younger children

Limited understanding of social “rules”

- Circles program

Limited “enthusiasm” for stopping when told

- 1,2,3, “STOP” program

Less emotional self regulation

NEED close supervision – esp toilets

ADHD and CSA

A BIG problem

Under-recognised / under-researched (says me!)

Both

- Effect of CSA (inattentive
- Contributor to abusive behaviour
- Poor impulse control

Crime stats: Trend downwards in CSA ~ trend upwards in use of Stimulant s ??? Coincidental???

Attachment disorders and CSA

2 types of RAD

- Aloof, disengaged, “autistic features”
- Hyperactive, intrusive, feral, “PLEASSSEEE love me”

Sexualised, overly affectionate, indiscriminate child
TRADE touch/sex FOR love/ attention / affection

Not a common association
Monitor safety of children in out of home care

The sexually corrupted child

Maladaptive learned patterns of behaviour

- Overly interested in sexual matters
- Eroticised
- Coquetish / flirtacious / expecxtaations of sexual response

View interactions with others as sexualised

- Generalised to affect world view *(I please people when I give them what they want)*
- Corrupted sense of self *(I am (only) worthy / a worthwhile person when I give others pleasure / do what they want)*

- At risk of sexually abusing others / Procure others for an abuser ???? Speculation

Mood disorders and CSA

Strong link between CSA and depression later in life

- Gene-gene-environment "dance" (Heim et al)
- Suicide risk
- Gender differences (F > M)
- Neuro-biologic consequences of abuse

More frequently the effect of CSA than the cause

More likely to be "self directed" rather than assaultative

Common features in children who offend

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- Average to low average IQ
- Learning problems
- Aggression
- Poor social skills, impulsive
- High degrees of sexual preoccupation
- Poor relationships with adults
- All girls sexually abused, 50-75% of boys
- Most had been severely and erratically physically punished

Predictive Factors Offending in sexually abused children

100 sexually abused children, aged 3-7 years
Sexual arousal during sexual abuse
Physical abuse
Emotional abuse
Perpetrator's use of sadism

Hall et al. Child Abuse & Neglect 1998

224 former male victims,
26 committed sexual offences
Material neglect
Lack of supervision
Sexual abuse by a female
Serious domestic violence
Cruelty to animals

Salter et al Lancet 2003

References

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