SEXUAL DEVELOPMENT AND SEXUAL BEHAVIOR PROBLEMS IN CHILDREN AGES 2-12

The National Center on Sexual Behavior of Youth has published a document called the NCSBY Fact Sheet. It provides basic information about sexual development and problematic sexual behavior in children ages 2-12. In this issue of the newsletter we will look at some common misconceptions.

COMMON MISCONCEPTION
1. All sexual behavior between children is normal, acceptable play.

CURRENT FINDING
1. Some sexual behavior between children is not appropriate.

Sexual behavior between children is considered problematic when the sexual behavior: a) occurs at a high frequency; b) interferes with child’s social or cognitive development; c) occurs with coercion, intimidation, or force; d) is associated with emotional distress; e) occurs between children of significantly different ages and/or developmental abilities or f) repeatedly reoccurs in secrecy after intervention by caregivers.

COMMON MISCONCEPTION
2. Sexual acts between children are not harmful.

CURRENT FINDING
2. Sexual acts between children can be significantly harmful.

Some sexual play between young children close in age, such as playing doctor or looking at private parts, is not considered to be harmful. However, some children display intrusive, aggressive, or coercive sexual behaviors which are potentially harmful to the other children involved.

COMMON MISCONCEPTION
3. Children with SBPs have been sexually abused.

CURRENT FINDING
3. Many children with SBPs have not been sexually abused.

Research on children with SBPs has shown that highly inappropriate or aggressive sexual behavior is not always an indicator that a child has been sexually abused. In separate groups of children with SBP’s, between 4% and 62% have no known history of sexual abuse. It appears that sexual behavior problems in children have multiple origins. Family sexuality patterns, exposure to sexual material, other non-sexual behavior problems, exposure to family violence, and physical abuse can be important contributors to childhood sexual behavior problems.
COMMON MISCONCEPTION
4. Children who have been sexually abused later act out sexually with other children.

CURRENT FINDING
4. Most children who have been sexually abused do not have sexual behavior problems.

Children who have been sexually abused have been found to exhibit more frequent and intrusive sexual behaviors than children with no history of sexual abuse. However, research suggests that most children who have been sexually abused do not have sexual behavior problems.

COMMON MISCONCEPTION
5. Girls rarely have sexual behavior problems.

CURRENT FINDING
5. Many children with SBPs are female. In research on school-age children with SBPs, about one-third were female, while a recent study on preschool children found that a majority were girls (65%).

COMMON MISCONCEPTION
6. Children with SBPs should not live in a home with other children.

CURRENT FINDINGS
6. With appropriate treatment and careful supervision, most children with SBPs can live safely with other children. Although research has not directly dealt with this issue to date, clinical experience indicates that many children with SBPs can remain in their home or a foster home with other children without problematic sexual behavior. However, children who continue to exhibit highly intrusive or aggressive sexual behavior despite treatment and close supervision should not live with other young children until this behavior is resolved.

COMMON MISCONCEPTION
7. Children with SBPs should be placed in specialized inpatient or residential treatment facilities.

CURRENT FINDINGS
7. Outpatient treatment can be successful for most children with SBPs. Most children can be successfully treated and managed on an outpatient basis while living at home. Inpatient treatment should be reserved for unusually severe and serious cases, such as a child with other psychiatric disorders and/or highly aggressive sexual behavior which recurs despite appropriate outpatient treatment and close supervision.

COMMON MISCONCEPTION
8. Children with SBPs should not attend public schools.

CURRENT FINDINGS
8. Most children with SBPs can safely attend public schools. Most children can attend public schools and participate in school activities without jeopardizing the safety of other students. Children with serious, aggressive sexual behaviors may need a more restrictive educational environment.

COMMON MISCONCEPTION
9. Without long-term intensive therapy, children with SBPs will continue to have sexual behavior problems.

CURRENT FINDINGS
9. Most children do not continue to have SBPs. Treatment outcome research has demonstrated that most children show significantly lower sexual behavior problems after short-term outpatient treatment (12-32 weeks). The recidivism rates for children 6-12 were approximately 15% two years after treatment.

COMMON MISCONCEPTION
10. Children with SBPs grow up to be adult sexual offenders.
10. **Most children with SBPs do not demonstrate continued SBPs into adolescence and adulthood.** Future SBPs by children appears to be low. Further, most adult sexual offenders do not report a childhood onset for their behavior. The relationship between childhood sexual behavior problems and adult sexual offending has not been documented in the research to date.

Additional information about adolescent sex offenders and children with sexual behavior problems is available from the National Center on Sexual Behavior of Youth, www.ncsby.org. References for the above article are also available at this site. This information was duplicated with permission from the National Center on Sexual Behavior of Youth.

**MEET MOLLY BERKOFF, OUR MEDICAL DIRECTOR**

By: Adam Zolotor, MD

Molly Berkoff has been a friend and colleague for the past six years. She grew up in Boston. She attended medical school at Columbia University in the Big Apple, and completed a residency in pediatrics at Yale University in New Haven, CT. After residency, we were lucky to attract her to North Carolina to study research and scholarship methods, child abuse pediatrics, and preventive medicine. She is a board certified in general pediatrics and child abuse pediatrics. She joined the faculty at UNC Chapel Hill in 2004 and we have been lucky to keep her here since. She quickly rose in the general pediatrics division because of her talent as an administrator, serving as the medical director for the Beacon Child Protection Team, the Child Abuse Evaluation Clinic, and the NC Child Medical Evaluation Program. She keeps a busy clinical schedule, seeing patients in the child abuse evaluation clinic and in-patient consults for suspected child maltreatment victims as well as teaching general pediatrics in the resident outpatient clinic. She maintains an active interest in pursuing research and scholarly work with interests in developmental and behavioral consequences and care for maltreated children, sexual abuse examination, and administrative structures to support health evaluations of children under the evaluation and care of social services. She published a landmark systematic review in JAMA in 2008 synthesizing the scientific literature on child sexual abuse exam findings.

In addition to being a talented, supportive, and kind colleague, Molly, is the proud mother of two busy boys, Cooper, 4, and Riley, 6. Cooper is in preschool and Riley is in Kindergarten. They are both soccer superstars and Riley is an up and coming UNC FARM swim team member. Molly is married to David Berkoff, an Emergency and Sports Medicine physician at the other local medical school. When Dave is not at work or with his family, he can usually be found on his bicycle (cycling is his avocation and medicine pays the bills). When Molly is not at work or with her family, she can usually be found hitting the pavement and trails of Chapel Hill in her running shoes. She recently competed admirably in the Tar Heel Ten Miler (April) and the Cooper River Bridge 10 K in Charleston, SC. Her other favorite activity is cheering for her sons in soccer games and swim meets.