

# Understanding and Treating the Sexually Acting Out Child

By:

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Recently, a parent asked, “Is it normal for two-year-olds to touch themselves or does that mean they’ve been sexually abused?” This is not an uncommon question from concerned caregivers, especially when children begin to exhibit sexual behaviors. However, to answer this question, it is important to understand child sexual development and the differences in sexual reactivity and sexual offense, which are often confused. Like most trauma responses, sexual reactivity is a normal response to an extreme event—the event of being sexually abused (Dominguez, Nelke, & Perry, 2006). Many clinicians who work with children who have been sexually abused understand that sexual reactivity can be a part of the process of sexual abuse. However, for those that do not work with these children, sexualized behaviors can be confusing and worrisome. Given this, it is important to be able to distinguish between healthy sexual development in children and the sexual behavior of children who have been sexually abused.

## Origins of Sexual Reactivity

According to the National Children’s Alliance (2009), between January and June of 2009, 129,548 children were served at Child Advocacy Centers in the United States. Of these children, 94,689 were served in response to sexual abuse. Children experiencing sexual abuse may experience a number of short- and long-term symptoms, including enuresis and encopresis (Homeyer & Landreth, 1998). Children who have been sexually abused may also experience a change in appetite, nightmares, aggression, over compliance, age inappropriate knowledge of sexual behaviors, fear of previously unfeared persons (Childhelp, n.d.; Levine & Kline, 2007), problems maintaining peer relationships, genital discomfort, dissociation, regressive behavior, mood swings, and sexually transmitted diseases (Levine & Kline, 2007). Dominguez, Nelke, and Perry (2006) report that approximately one-third of children who experience sexual abuse may also begin to express sexually reactive behaviors.

### **Sexual Reactivity Defined**

Sexual reactivity in children is a common response following sexual abuse (Dominguez et al., 2006). For children who have been sexually abused, inappropriate sexual behaviors may be a learned form of relating to and communicating with others. However, for those who work with children, it is important to distinguish normal sexual play from sexually acting out behaviors. It may be helpful to consider the following characteristics when differentiating between age-appropriate sexual play and sexual reactivity, as these indicators may be indicative of sexual abuse and sexual reactivity (Ruggles, 2009):

- Is there a history of sexual abuse (suspected or substantiated)?
- Does the child simulate sex acts with dolls, toys, animals, other children, and adults?
- Is there knowledge of sex that is more advanced than the child's age level?
- Are there poor boundaries, particularly related to touch, the child's body, or touching his/her body?
- Is behavior provocative, flirtatious, or promiscuous with others?
- Does the child touch other children and adults inappropriately and/or in public (breasts, vagina, groin, buttocks)?
- Does the child masturbate, self-stimulate, or expose his/her body to others?
- Are there sexualized themes during play and conversations, including drawing, painting, and playing with dolls and dollhouses?

### **Sexual Offender Defined**

The question then becomes whether the child who sexually acts out may be in danger of being considered a sexual perpetrator. Again, it is helpful to consider the following when differentiating between a sexually reactive child and a juvenile perpetrator. A sexual perpetrator may (Ruggles, 2009)

- use threats of harm, coercion, or bribery to keep the sexual acts a secret
- use lies or manipulations to avoid the truth when confronted
- use violence, weapons, implements, and objects during sexual acts
- use force or intimidating behaviors

Additionally, legislation provides guidelines for defining sexual abuse that serves as a minimal standard for all stages, which identifies sexual abuse as

the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct. (U.S. Department of Health and Human Services, 2004, p. 44)

Commonly, children who are experiencing sexual reactivity do not engage in the above-listed behaviors. Their sexualized behaviors, while at times involving other individuals, are a response to their own traumatic experience or experiences (Dominguez et al., 2006) therefore distinguishing them from sexual offenders.

### **Sexual Development and Play**

Sexual development and sexualized play are a natural and healthy process for children.

Although all children develop at different rates, there are certain behaviors and experiences that are commonly observed among certain age groups. For instance, babies and toddlers may be observed rubbing their genitals during diaper changes. According to Dunn, Myers-Walls, and Love (2006), children from the ages of birth to two are often very curious about their bodies. At this stage of development, touching and self-stimulation are normal. This experience is calming and soothing, rather than sexually exciting, as it may be for teens and adults.

Children ages two to five years may continue to explore their bodies. At this age, children are learning about privacy, they may be interested in looking at others naked, and they are learning about their different body parts (Dunn et al., 2006). This is a time in childhood when masturbation and sexual play may be heightened. At this stage, caregivers may need to set rules regarding when and where this type of experience is to occur, without creating an atmosphere of shame. For example, the caregiver can say, "It feels good to rub your penis/vagina, but this is something that's okay to do in private, like in your bed at nighttime."

School-age children, ages six to nine, continue to be curious about their bodies and the bodies of others and may begin sexual play with other children, such as playing "Doctor." They may be heard telling other children "dirty" jokes. Their knowledge of sexual matters continues to

expand through this period, and children in this age range may begin to enter the first stages of puberty (Dunn et al., 2006).

Children within the 10 to 12 age range, the preteen child, begin to have clearer concepts about love, sex, and relationships. Sexual development during this period is extremely active (Dunn et al., 2006) and hormones begin to influence interactions with peers. By the time they have reached adolescence, children are moving deeper into intimacy and relationships. Sexual behaviors become more common, including petting, regular masturbation, and intercourse. However, when a child is sexually abused, there is a significant disruption to this natural progression (American Academy of Pediatrics, 2005).

### **Sexually Reactive Behaviors in the Therapy Room**

Children are known to use play to work out their problems, using toys and metaphors to process their experiences and resolve their inner conflicts (Axline, 1964; Axline, 1969; Findling, Bratton, & Henson, 2006; Landreth, 1991; Muro, Ray, Schottelkorb, Smith, & Blanco, 2006; O’Conner, 2000). According to Oaklander, “children experience much in life they find difficult to express in language, and so they use play to formulate and assimilate what they experience” (2001, p. 45). When provided with the therapeutic space for creative expression, children may process their experiences in a variety of ways that may be daunting for the unsuspecting clinician.

According to Ater (2001), there are several expressive actions a client who has experienced sexual abuse may engage in when working in a creatively friendly therapy room.

- *Dissociative experience*: In this form of expression, a client may dissociate from the current experience, as it may become too overwhelming for the child to process with his/her current level of coping skills. This can look like a child is “checking out” and staring into space for extended periods of time. When the child returns to play, he/she may have little to no memory of the dissociation and may deny certain actions.
- *Nurturing play*: Children who have been sexually abused may express their need for nurturing in the therapy room by utilizing available materials or through interactions with the clinician. They may ask the therapist to nurture them, as well as demonstrate the need to be nurturing to others.
- *Abreaction*: Much like adults, processing a traumatic event or events is not a singular experience for children. Therefore, it may take many episodes of “talking about,” or in a

child's language, playing out, the traumatic experience, to increase mastery, control, and healing. Many children recreate or reenact the trauma through their play repeatedly.

- *Perseveration*: Perseveration, similar to the catharsis of abreactive processing, involves the repetitive enactment of a traumatic experience. However, instead of increasing mastery and control and moving toward healing, in perseveration, a client may become “stuck” in his/her reenactment and have difficulty finding a hopeful resolution to the traumatic experience.
- *Sexualized play*: Sexualized play may take many forms in the therapy room. Children may engage in *abuse-reactive* play, whereby the abuse event may be replayed in some form in the therapy room and incorporate the therapist into the play to test the boundaries of the therapeutic relationship. A second form of sexualized play often seen in the therapy room is *symbolic sexualized play*. In this form of play, children engage in sexualized play as they work to gain mastery, understanding, and acceptance of their abuse experience. During this form of play, children must learn how to form and maintain relationships with those in the world in a non-sexual manner. A final form of sexualized play that may be seen within the therapy room is *reenactment play*. During reenactment play, children may reenact the trauma event, both physically and emotionally.

The experiences identified by Ater (2006) provide a general and broad base of behaviors that clinicians might experience within the therapy setting. Other, more specific behaviors, that might be experienced may include, but are not limited to

- abusive or negative nurturing play, often representing the abuse experience
- drawings as an expressive medium, particularly where parts of the body may be missing or disfigured (eyes, genitals, mouth, hands)
- aggressive play as a way to gain a sense of power and control in a world that may seem out of control
- self-stimulation (indirect: squirming in chair / direct: sitting on feet with feet pressing into the genitals, pressing objects into the genital area)
- sexual verbalizations (observational comments or comments made for effect)
- “I love you/I hate you” relationship reenactment
- discussing body fluids

- aggression toward genitals of dolls
- play with a two-headed dragon
- cleaning/cleansing play with water and/or sand
- burying/hiding play of self/objects in sand/blankets
- stripping off clothing

### **Techniques**

It is important to utilize appropriate creative techniques when working with children who are sexually reactive. Typically, these children demonstrate difficulty expressing their emotions, setting clear boundaries for themselves and utilizing effective coping strategies when faced with challenges. Clinicians using techniques in these key areas will assist children in the much needed mastery of their sexual abuse history, thereby addressing the sexually acting out behaviors.

### **Feelings Expression**

Hide and Seek Feelings (Kenney-Noziska, 2008) is used to help children learn to identify their emotions and begin to express these emotions.

*Materials Needed: Crayola Color Changeable Markers, index cards*

Using the “invisible” marker from the changeable markers, identify several feelings the child may be experiencing on index cards. For younger children, it is helpful to draw feelings faces, again using the “invisible” marker. Hide the cards throughout the office, allowing the child to find the cards. Once he/she has found the cards, the child can use a colored marker to reveal the hidden feelings. The therapist can then begin to process with the child how those feelings might relate to his/her sexualized behaviors.

Target Your Feelings (©Juliet Fortino, MC, LPC, RPT-S) is another technique that can be used to help children recognize and communicate their feelings.

*Materials Needed: Butcher paper, markers, ammunition (e.g., cotton balls, dart/dart gun, soft balls)*

On a large sheet of butcher paper, the therapist draws a target. It is helpful to have several concentric circles with enough space to write within each circle. The child’s name is written in the smaller, middle circle. In each outer circle, the therapist identifies feelings the child might be

experiencing related to his/her sexual reactivity (i.e., shame, guilt, excitement). The child is encouraged to throw the ammunition at the target. If the ammunition lands on the child's name, the child can identify any feeling he/she wishes and then discuss a time he/she felt that emotion. If the ammunition lands on any of the other feelings, the child has to identify a time he/she felt that emotion and relate it to his/her sexualized behaviors.

## **Boundaries**

Bodies and Boundaries (©Juliet Fortino, MC, LPC, RPT-S) is an activity that can help children relate to their bodies and begin to understand their own boundaries.

*Materials Needed: Paper doll cut-out, paper, art/craft supplies (e.g., stickers, feathers, glue, buttons, magazine cut-outs)*

Attach a paper doll cut-out to a larger piece of paper. Allow the child to decorate the cut-out as a self-portrait. Once completed, engage the child in a discussion about the importance of boundaries. Through this discussion, help the child understand that not all boundaries are visible (i.e., the ones around our bodies). Once the child understands these concepts, have the child draw his/her boundaries on the paper cut-out. Questions to help the child along can include (1) Where is it not okay to touch others? (2) Where is it okay to hug people? (3) Where is it okay to kiss people?

The OK to Say No Game (Crisci, Lay, & Lowenstein, 1998) is an activity that facilitates boundaries by helping children learn to use assertiveness appropriately. An "OK to Say No" game board is available in *Paper Dolls and Paper Airplanes*. Using the game board, the therapist helps the child learn to use "no" in appropriate situations.

The Twizzler Test (Goodyear-Brown, 2002) is another boundary activity that engages children in understanding personal space.

*Materials Needed: Twizzlers candy*

Children are provided with a set of Twizzlers to use as "measuring rods." The Twizzlers are laid out on the floor as a visual cue for appropriate boundaries and personal space. Each child must use the Twizzlers to determine how many Twizzlers are an appropriate distance between (a) parent and child; (b) two friends; (c) child and teacher; and (d) child and stranger. Children are

then engaged in discussion by asking questions such as (1) What is a physical boundary? (2) Why are boundaries important? (3) What can the child say if someone gets in his/her personal space?

### **Coping Skills**

Bagful of Tricks (©Juliet Fortino, MC, LPC, RPT-S) is an activity that gives children a visual reminder of identified coping strategies.

*Materials Needed: Brown paper bags, art supplies (e.g., stickers, glue, feathers, ribbon), markers, crayons*

On a brown paper bag (lunch-bag size), have the child create a self-portrait. The outside can look however he/she chooses. After the outside of the puppet is complete, engage the child in a discussion about feelings, triggers, and behaviors. If needed, the child can decorate the inside of the puppet with how he/she feels inside when acting out sexually. As the child uncovers a trigger, feeling, or behavior, ask the child to identify a possible coping strategy for that behavior. Write each coping strategy down on a piece of paper and put it inside the paper bag. Help the child associate that coping strategies are always inside of him/her and just need to be pulled out when they are needed.

Pieces of Me (Barnes, 2010) is an activity that helps children identify their own support systems.

*Materials Needed: Pieces of Me worksheet, markers, crayons*

Using the Pieces of Me worksheet (a heart divided with lines like a puzzle), allow the child to identify all the people in his/her life with whom he/she feels safe, who helps and who supports him/her. The child lists these individuals in the spaces created within the heart. The child can then identify one characteristic or quality that makes these people important. These people and their qualities can then be added to the pieces of the heart. Process questions for this discussion can include (1) What quality got each person onto the list? (2) What are some characteristics that the child values in people? (3) Do those people have qualities that the child also has?

The Right Medicine (©Mistie Barnes, M.Ed., LPC-S, RPT-S) is another activity that assists children in self-soothing and control.

*Materials Needed: Empty medication bottle (label removed), self-adhesive labels, strips of colored paper, scissors*

The activity begins with a discussion about why people take medication, with the general idea of medication being used to help people feel better. Using the different colored strips of paper, list thoughts that relieve/reduce anxiety on one color of paper, feelings on another, and positive memories on a third. Then create a name for the medication and instructions for use of the medication (i.e., take one feeling every morning). Using the name and instructions, create a label to attach to the medicine bottle. Children can then take their medication with them to help reduce and relieve their thoughts and feelings throughout the day.

### **Conclusion**

Sexual reactivity among children, whether exhibited in school, at home, or in the therapy room, can be a disconcerting experience for adults. To ensure that the most effective treatment is provided, it is important to understand several key concepts. First, it is important to have an understanding of child psychosexual development and the differences between sexual reactivity and sexual offender behavior. Next, clinicians should learn how to respond to sexually reactive behaviors in the therapy room in a manner that encourages expression and healing rather than shame and avoidance. Finally, it is important for clinicians to have a repertoire of creative techniques for working with children who exhibit sexually reactive behaviors. The knowledge and understanding of a well-informed clinician will assist sexually responsive children and their families find ways to better communicate their feelings, strengthen their understanding of boundaries, and improve their coping mechanisms.

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### **Biographies**

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