Female Caregivers' Perception of their Child's Sexualized Behaviors: A Pilot Study at a Child Protection Clinic

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ABSTRACT

This pilot study explored female caregiver's perception of their child's behaviors during sexual abuse evaluations. We compared reports by caregivers with histories of their own child sexual abuse (PCSA) to caregivers with no prior history of child sexual abuse (NPCSA) regarding their 1) child's sexualized behaviors and (2) perceptions of whether their child had been sexually abused. Forty-four caregivers met inclusion criteria. Ninety-five percent of PCSA caregivers versus 21% of NPCSA caregivers reported at least one behavior from the Child Sexual Behavior Inventory. Our findings identified that PCSA caregivers reported more sexualized behaviors for their children overall, potentially contributing to their perception that their child had been sexually abused. This pilot study demonstrated that caregivers were able to tolerate answering questions about their own history of child abuse. Parents should be asked these questions as this may influence perceptions of their child's behaviors and possible sexual abuse.

KEYWORDS: child sexual abuse, adult survivor of sexual abuse, child sexualized behaviors

INTRODUCTION

A history of childhood sexual abuse (CSA) influences a person's parenting characteristics.[2,4,5,6,7,16] Mothers with their own histories of CSA have been shown to be hypervigilant about the possibility of their child(ren) being sexually abused.[3] These mothers describe the rewards and obstacles of parenting in more self-focused rather than child-focused ways, and more often refer to their child as a friend compared to mothers without a history of CSA.[2] Mothers with a CSA history show more permissive parenting styles, lower reported parenting self-efficacy,[6,7,16] and are more likely to be overly dependent on their children to meet their own emotional needs than mothers without a CSA history.[4,18] Children whose mothers have experienced CSA have been found to have higher rates of problematic behaviors and are more likely to report having been sexually abused by a person known to the child.[1]

Normal sexualized behaviors are common, transient, non-aggressive, involve similar aged children, and can be redirected.[19] Behaviors considered abnormal and raise concern for possible sexual abuse or exposure to adult sexual material are imitative of adult sexual acts, associated with aggression, involve coercion, and/or are difficult to redirect the child away from.[11,19] When a child has developmentally inappropriate sexualized behaviors, or behaviors that a caregiver perceives to be developmentally incongruous, they may be referred for a CSA evaluation.[19]

Clinicians rely on a caregiver's report and perception of their child's sexualized behaviors during a child's evaluation for possible sexual abuse. Given that parenting styles differ depending on the mother's CSA history, there may be important clinical implications to understanding a mother's CSA history and how it may influence her reporting and perceptions of her child's behaviors. A child's sexualized behaviors may be assessed by using the Child Sexual Behavior Inventory (CSBI), a 38-item parental report measure of sexualized behavior in children ages 2 to 12.[8] The CSBI includes three scales that aid in the interpretation of the results. The CSBI was validated only with reports by female caregivers and can help to inform clinicians' decisions about diagnosis and treatment of CSA and can help assess whether a child is displaying abnormal sexualized behaviors.[8]

To date there is no research comparing differences in reporting child sexualized behaviors, made by female caregivers with a history of CSA to female caregivers without a history of CSA. Using the CSBI, this pilot study compared female caregivers with a history of prior child sexual abuse (PCSA) with female caregivers with no prior history of child sexual abuse (NPCSA) regarding (1) reports of their child's sexualized behaviors and (2) their perceptions of whether their child had been sexually abused. This study also assessed the feasibility of asking female caregivers detailed questions about their own history of CSA. This research may inform clinicians about the potential influence a history of CSA has on a female caregiver's perception of their child's sexualized behaviors.

METHODS/PROCEDURES

Sample

The population for this study was female primary caregivers accompanying their child to a hospital-based child protection clinic for the evaluation of CSA. Inclusion criteria for

participation were: a female caregiver who was (1) a biological, step, adoptive parent, or guardian (established through private arrangement not through a child welfare agency), (2) 18 years of age or older, (3) proficient in English, and (4) accompanying their child (between the ages of 2 and 12). Male caregivers were excluded because the CSBI has not been validated among male caregivers. Participation was voluntary and anonymous.

Measures

The questionnaires were written at a 5th-grade level, self-administered, and had three parts:

Part 1: Questions about primary female caregiver

Information collected from the caregiver included whether they had a history of CSA. Those that reported their own history of CSA were then asked to provide additional information about their sexual abuse, if they received any mental health intervention specifically related to the CSA and if the treatment was perceived to have been helpful.

Part 2: Questions about the child

Information collected from caregivers about the child included demographics, and if the caregiver thought their child had been sexually abused. Caregivers who thought their child was sexually abused were asked to provide details of the sexual abuse.

Part 3: CSBI

Caregivers completed the 38 item CSBI to assess their child's sexualized behaviors in nine domains: boundary issues, sexual interest, exhibitionism, sexual intrusiveness, gender role behavior, sexual knowledge, self-stimulation, voyeuristic behavior, and sexual anxiety.[8,10] Three clinical scales were calculated: the CSBI total scale, the Developmentally Related Sexual Behavior (DRSB) scale, and the Sexual Abuse Specific Items (SASI) scale.[8] The CSBI total scale gives a comprehensive assessment of the sexual behaviors the child exhibits. The DRSB scale reports sexual behaviors considered normal for the child's age and gender.[8] The SASI scale reports sexual behaviors considered atypical for the child's age and gender.

After completing the questionnaires and inventory a clinician not involved in the child's evaluation debriefed with the caregiver and assessed their emotional response regarding participation in this study. This additional assessment was completed to provide psychological supports and interventions if determined to be clinically indicated.

Data collection and procedures

This cross-sectional pilot study included two phases. In the first phase (February 2015), the surveys were completed by five of the nine caregivers approached, the remaining four declined, to assess the feasibility, content, and psychological response by the caregivers being asked details about their own CSA history. After they completed the questionnaires and CSBI, each caregiver was asked for feedback, which was used to modify the questions prior to implementing the second phase. In the second phase, data were collected from a convenience sample between March 2015 until August 2016.

Before their child's evaluation, potential participants (caregivers) were approached by a child abuse pediatrician or social worker who was not involved in the child's evaluation. Using a prewritten script, potential participants were screened to determine if they met inclusion criteria. Verbal consent was obtained. Eligible and consented individuals were asked to complete a three-part self-administered questionnaire. Participants completing the questionnaire received a $10 gift certificate. A clinician remained in the same room as the participant, to answer any questions. Due to the sensitive nature of the questionnaire, the clinician debriefed each participant after completion to assess any need for a mental health referral or intervention.

Data management and statistical analysis

Responses were collected and managed using Research Electronic Data Capture (REDCap) software.[15] Responses to the CSBI were scored to determine a score summary, which includes raw scores and T scores for the CSBI Total scale, DRSB scale, and SASI scale.

Caregivers and child demographics, caregivers' reports of child sexualized behaviors, and the three CSBI clinical scales were compared between caregivers with and without a history of sexual abuse using bivariate analyses. A p value of <0.05 was considered statistically significant. All analyses were conducted using STATA (Version 11.2, StataCorp, College Station, Texas). All procedures were approved by Rhode Island Hospital Institutional Review Board.

RESULTS

Sixty-seven caregivers were approached to participate in the study; 44 met inclusion criteria. The 23 caregivers who were not screened for eligibility included 13 who declined, nine who had started their child's sexual abuse evaluation before and therefore could not be approached to participate, and one caregiver who could not complete the survey because her child was sick and sent home.

Table 1 describes the demographic characteristics of the 44 caregiver participants. Of the 44 caregivers, 20/44 (45%) reported having a history of CSA and were categorized as prior child sexual abuse (PCSA); the remainder were categorized as no history of child sexual abuse (NPCSA). The majority of caregivers were biological parents (39/44, 84%) and employed (29/44, 66%). Half of participants reported a two-parent home (23/44, 52%) and over half identified as Non-Hispanic White (25/44, 57%). Seventy-three percent (32/44, 73%) of the caregivers thought their child had been sexually abused.

Table 1. Characteristics of female caregiver (n=44)

	Prior Child Sexual abuse n=20 (45%)	No history of Child Sexual Abuse n=24 (55%)	Total n=44
Relationship to child			
Biological parent	18 (90%)	21 (88%)	39 (89%)
Step parent	1 (5%)	1 (4%)	2 (4%)
Foster parent/guardian	1 (5%)	2 (8%)	3 (7%)
Single parent			
Yes	9 (45%)	12 (50%)	21 (48%)
No	11 (55%)	12 (50%)	23 (52%)
Employment Status			
Employed	11 (55%)	18 (75%)	29 (66%)
At home/other/student	9 (45%)	6 (25%)	15 (34%)
Education			
Some high school	3 (15%)	3 (13%)	6 (14%)
High school graduate	7 (35%)	8 (33%)	15 (34%)
Some college/technical	9 (45%)	8 (33%)	17 (39%)
College graduate	1 (5%)	5 (21%)	6 (14%)
Race/ethnicity			
Hispanic	6 (30%)	4 (17%)	10 (23%)
Non-Hispanic White	12 (60%)	13 (54%)	25 (57%)
Non-Hispanic Black	2 (10%)	5 (21%)	7 (16%)
Other	0	2 (8%)	2 (4%)
Has child ever been abused?			
Yes	15 (75%)	17(71%)	32 (73%)
No	5 (25%)	6 (25%)	11 (25%)
Unknown	0 (0%)	1 (4.2%)	1 (2%)

Table 2. Demographics of child (n=44)

	Prior Child Sexual abuse n=20 (45%)	No history of Child Sexual Abuse n=24 (55%)	Total n=44 (100%)
Gender			
Female	14 (70%)	15 (62.5%)	29 (66%)
Male	6 (30%)	9 (37.5%)	15 (34%)
Age of child			
2–5	8 (40%)	10 (42%)	18 (41%)
6–9	6 (30%)	11(46%)	17 (39%)
10–12	6 (30%)	3 (12.5%)	9 (21%)
Race/ethnicity			
Hispanic	2 (10%)	1 (4%)	3 (7%)
Non-Hispanic White	12 (60%)	11 (46%)	23 (52%)
Non-Hispanic Black	3 (15%)	6 (25%)	9 (21%)
Other	3 (15%)	6 (25%)	9 (21%)

Table 2 describes the child's demographic information. Most of the children were female (29/44, 66%), between the ages of 2 and 5 (18/44, 41%), and non-Hispanic White (23/47, 49%).

Table 3 presents the child's sexualized behaviors as reported by PCSA and NPCSA caregivers. The most common sexualized behaviors reported by the cohort of 44 caregiver participants were item 2 (Stands too close to people), item 12 (Touches sex (private) parts when at home), item 19 (Tries to look at people when they are nude or undressing), and item 35 (Is very interested in the opposite sex). These behaviors fell into the domains of boundary problems, self-stimulation, and voyeuristic behavior. Nineteen of the 20 PCSA caregivers (95%) reported at least one of the behaviors on the CSBI, whereas five of the 24 NPCSA caregivers (21%) reported at least one of the behaviors on the CSBI. Overall, PCSA caregivers reported more clinically significant CSBI, DRSB, and SASI scores for their child than NPCSA caregivers (**Table 4**).

Twenty-eight participants responded to questions about their experiences completing the questionnaire during debriefing. **Table 5** outlines their open-ended responses, when asked about their participation in the study. Five caregivers reported "okay," three "good," and two "fine." The rest of the responses were unique and not repeated. One caregiver who reported "okay" began to cry during debriefing because she was concerned that her child had been abused. No caregiver required psychological supports, interventions, or immediate mental health referrals due to participating in the study.

DISCUSSION

It is standard practice for clinicians conducting sexual abuse evaluations to consider sexualized behaviors, and to rely upon caregiver's reports of their child's sexualized behaviors. Thus, it is important to recognize potential factors that may affect caregiver reporting. The current study captured preliminary data to explore the potential influence a caregiver's CSA history may have on their perceptions and subsequent reporting of their child's sexualized behaviors.

This study reveals that caregivers who had previously experienced their own sexual abuse during childhood (PCSA) were more likely to report at least one of the behaviors on the CSBI, as compared to caregivers without a history of child sexual abuse (NPCSA). Additionally, PCSA caregivers reported more clinically significant CSBI, DRSB, and SASI scores than NPCSA caregivers. There are several possibilities to explain these findings, including that relative to NPCSA caregivers PCSA caregivers: 1) Are more aware of their

Table 3. Child sexualized behaviors reported by caregivers (n=44)

	Prior Child Sexual abuse n= 20		No history of Child Sexual Abuse n= 24		Both n= 44	
Dresses like the opposite sex	4	20%	1	4%	5	11%
Stands too close to people	10	50%	11	46%	21	48%
Talks about wanting to be the opposite sex	1	5%	1	4%	2	5%
Touches sex (private) parts when in public places	4	20%	5	21%	9	20%
Masturbates with hand	5	25%	3	13%	8	18%
Draws sex parts when drawing pictures of people	2	10%	0	0%	2	5%
Touches their mother's or other women's breasts	7	35%	7	29%	14	32%
Masturbates with toy or object	3	15%	5	21%	8	18%
Touches another child's sex (private) parts	5	25%	6	25%	11	25%
Tries to have sexual intercourse with another child or adult	0	0%	0	0%	0	0%
Puts mouth on another child's/adult's sex parts	1	5%	0	0%	1	2%
Touches sex (private) parts when at home	11	55%	10	42%	21	48%
Touches an adult's sex (private) parts	3	15%	4	17%	7	16%
Touches animal's sex parts	1	5%	0	0%	1	2%
Makes sexual sounds	2	10%	2	8%	4	9%
Asks others to engage in sexual acts with him or her	2	10%	2	8%	4	9%
Rubs body against people or furniture	5	25%	2	8%	7	16%
Puts object in vagina or rectum	2	10%	2	8%	4	9%
Tries to look at people when they are nude or undressing	9	45%	7	29%	16	36%
Pretends that dolls or stuffed animals are having sex	2	10%	1	4%	3	7%
Shows sex (private) parts to adults	6	30%	6	25%	12	27%
Tries to look at pictures of nude or partially dressed people	4	20%	5	21%	9	20%
Talks about sexual acts	3	15%	7	29%	10	23%
Kisses adults they do not know well	0	0%	3	13%	3	7%
Gets upset when adults are kissing or hugging	8	40%	5	21%	13	30%
Overly friendly with men they don't know well	3	15%	0	0%	3	7%
Kisses other children they do not know well	2	10%	0	0%	2	5%
Talks flirtatiously	3	15%	3	13%	6	14%
Tries to undress other children against their well	0	0%	0	0%	0	0%
Wants to watch TV or movies that show nudity or sex	3	15%	2	8%	5	11%
When kissing, tries to put their tongue in other's mouth	2	10%	3	13%	5	11%
Hugs adults they do not know well	3	15%	3	13%	6	14%
Shows sex (private) parts to children	3	15%	3	13%	6	14%
Tries to undress adults against their will	1	5%	1	4%	2	5%
Is very interested in the opposite sex	8	40%	6	25%	14	32%
Puts their mouth on mouth's or other women's breasts	2	10%	0	0%	2	5%
Knows more about sex than other children their age	8	40%	3	13%	11	25%
Caregiver reported ≥ one sexualized behavior listed above	19	95%	5	21%	38	86%

Table 4. CSBI score summary by history of child sexual abuse among female caregivers

	Prior Child Sexual abuse n= 20			No history of Child Sexual Abuse n= 24		
Score	Clinically Significant	Suggests Difficulty	Non-significant	Clinically Significant	Suggests Difficulty	Non-significant
CSBI	11 (55%)	1 (5%)	8 (40%)	9 (38%)	2 (8%)	13 (54%)
DRSB	9 (45%)	0 (0%)	11 (55%)	7 (29%)	2 (8%)	15 (63%)
SASI	9 (45%)	1 (5%)	10 (50%)	8 (34%)	2 (8%)	14 (58%)

CSBI scale raw scores and the corresponding T-scores for each age-gender group are available in the appendix of the CSBI Professional Manual. For all clinical scales, T scores at or above 65 were considered clinically significant. T scores in the range of 60 through 64 suggest difficulty and may indicate a clinical behavioral problem. T scores 59 or less were considered clinically nonsignificant (Friedrich, 1997).
*No significant differences found

Table 5. Open-ended responses of female caregivers about their participation in the study

Open-ended responses	Number of responses
Okay	5
Good	4
Fine	2
Feels weird	1
Same	1
Nervous	1
Never had therapy, relieving	1
The booklet is awkward	1
It's disturbing	1
Oh my God! Those questions are horrifying.	1
Fine. The questions are a little abrasive. Needed for something like this.	1
Weird questions	1
Good knowing she can see some of the same patterns	1
It was a little uncomfortable to think half of that stuff goes on.	1
Feels uncomfortable	1
Feels it's a good thing. Stuff like that should definitely be researched.	1
I don't know.	1
Think I made a good choice if something to benefit kids sexually abused. Some questions were graphic but for 12 years old who was sexually abused it may affect them more.	1
A little disturbing to know that stuff goes on.	1

child's sexualized behaviors, 2) Recognize the relevance of sexualized behaviors and are more willing to report this during an evaluation, based upon their own experience. Since this study did not capture data on whether a diagnosis of sexual abuse was made for any of the children evaluated, it cannot be used as a factor to interpret these differences in reporting. Additional research with larger sample sizes is needed to further examine differences between PCSA caregivers and NPCSA caregivers regarding perceptions of their child's alleged sexual abuse and reported behaviors.

Hypervigilance and increased reporting may be a developed response among caregivers due to their own trauma history. This concept has been explored by others. In a 2015 qualitative study of 44 mothers who had been sexually abused as children, three common themes related to their parenting emerged: (1) efforts to protect their children, (2) reactions to real or imagined abuse, and (3) belief that their children were victims. The study suggests that the mothers' CSA histories directly impacted their concerns that their child had been sexually victimized.[3] Consistent with these prior findings, our participants' recognition of any sexualized behavior, and slightly increased awareness of clinically significant sexualized behaviors, may be related to their concern that their child had been sexually abused.

Due to the sensitive subject matter, a clinical research team member was available to professionally address any concerns or provide resources to participants. When debriefed about participating in this study, a majority of caregivers reported a neutral or positive response. This suggests that it is feasible to explore sensitive clinical research questions with previously victimized female caregivers. As commonly experienced by clinicians that conduct child sexual abuse evaluations, one caregiver expressed anxiety related to the possibility of her child being sexually abused, rather than to her own abuse history or participation in the study. Notably, six caregivers volunteered positive feedback about the survey, their support for the research, and their understanding of the questions. One caregiver said, *"[I] feel it's a good thing. Stuff like that should definitely be researched."* Feedback from our participants indicates that clinicians can have conversations about a caregiver's own experiences of sexual abuse during their child's sexual abuse evaluation. A caregiver's own experience should be discussed given its relevance to the child undergoing a child sexual abuse evaluation.

This pilot study has several limitations. It was a small convenience sample and was conducted at a single institution. Therefore, findings cannot be generalized beyond the included sample. The CSBI is standardized only for female caregivers, and therefore other caregivers' perceptions were not included. The caregiver was approached intentionally before the sexual abuse evaluation started; the results of the sexual abuse evaluation was unknown to the caregiver when they answered the questionnaires and the caregiver's responses were not shared with the clinical team completing

the child sexual abuse evaluation. The outcome of whether the children evaluated were diagnosed with child sexual abuse was not included and therefore, this study cannot be used to assess if the caregiver's reports and perceptions were accurate or due to hypervigilance. Finally, participants were asked to recollect events from their own childhood, which due to the passage of time or the traumatic nature may result in recall bias.

Future research

A larger sample size is needed to further explore and confirm our preliminary findings about differences in reporting of sexualized behaviors between caregivers with and without their own childhood history of sexual abuse. Additionally, a study examining provider bias would be a valuable contribution; previous literature identifies that clinicians may perceive mothers with a history of CSA to misinterpret, or be hypervigilant of, innocuous behaviors due to their own prior experiences.[5] Therefore, another important factor for consideration in future research is how a caregiver's report of their own history of sexual abuse influences the clinician while conducting the child's evaluation and making a diagnosis of child sexual abuse. Finally, further investigation is needed to determine if there is a difference among caregivers with and without their own history of child sexual abuse, with regard to perceiving their child's sexualized behaviors as abnormal and an indication of potential sexual abuse warranting evaluation and ultimately whether a diagnosis of sexual is made.

The CSBI is a limited inventory of children's sexualized behaviors because it is validated only for female caregivers. The CSBI should be validated considering the gender identity of all caregivers.

CONCLUSION

Our findings raise important considerations for practice, and preliminarily suggest that caregivers with a personal history of sexual abuse may be more aware of their child's sexualized behaviors overall and may interpret their child's sexualized behaviors differently than caregivers without an abuse history. Our data provides foundational information about the importance of asking caregivers about their own abuse history in the context of their child's sexual abuse evaluation and demonstrates that caregivers are willing to answer these questions.

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