

## Situating unusual child and adolescent sexual behavior in context

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Generally, review articles are intended to guide and update clinicians. When we accepted this task, we knew that the existing data about unusual childhood sexual behaviors were minimal and that most of the common beliefs in this area were based upon preconceived notions. We performed an extensive literature search but the lack of evidence for even the most basic information was surprising. Although some literature exists about conventional sexual behaviors (eg, heterosexual coitus, masturbation), unusual interests have been ignored for the most part in children and adolescents. There has been voluminous attention to youthful sex offenders, although this represents a legal category rather than a clinical population, and epidemiologic data is largely absent. The literature focuses almost exclusively on young males, with a dearth of attention to unusual sexual behavior in females.

Parents routinely ask clinicians about the sexual activities of their children and adolescents. Most of these concerns are dealt with easily, appropriately or otherwise, and the activities are deemed to be part of normal sexual development. A few unusual sexual concerns are referred for further assessment, diagnosis, and treatment. Existing scientific theory—actually hypotheses—are short on empiric data. It is difficult to discern what is unusual if one does not know what is usual. It is not clear which unusual behaviors are signs of future problems and which are just uncommon. Treatment of children and adolescents with unusual sexual behaviors without data on the effectiveness of different modalities can be risky; follow-up studies also are lacking. Our best advice is to “First, do no harm” and re-evaluate methods frequently. Children are not little adults; evaluation and

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treatment techniques for adults, in general, should not be generalized to children. Children and adolescents who present with unusual sexual behaviors provide practitioners with complex assessment, diagnosis, and treatment challenges.

The inability to define unusual sexual behavior has made our task much more difficult. For example, someone who is more interested in sexuality than the one who is making the judgement might be called “sexually obsessed.” Similarly, in comparison with the evaluator, masturbating more is seen as excessive, having more partners is characterized as promiscuous, and having more frequent sex is regarded as nymphomania or satyriasis. Having a sexual interest that is different from the evaluator usually connotes that the interest is unusual, if not pathologic. About 100 years ago, physicians treated “hysteria” in women by masturbating them to “paroxysmal convulsions” (ie, orgasm) [1] while also warning of serious health risks from masturbation [2]. Our understanding of developmental sexuality has not changed greatly since that era. It is important to proceed carefully and not allow the current moral climate to influence unduly the clinical interpretation of unusual sexual behaviors.

In our experience, adolescents rarely request help for unusual sexual concerns from their caregivers; they “understand” that sex is not a discussion topic. It is the caregiver who becomes concerned and seeks further evaluation. Parents or school authorities who are worried about the appropriateness of particular sexual behaviors usually refer these patients, but only after attempts to exert control have failed. Courts also refer adolescents for a wide range of sexual offenses, some of which would constitute serious crimes if committed by an adult and some of which would be ignored if committed by an adult. Practitioners are asked to assess the nature and scope of the behaviors in question to determine whether they are pathologic and require diagnostic classification, are problematic but nonpathologic, or are stage-appropriate sexual behaviors. Practitioners must evaluate what is “normal” and what is “abnormal” sexual behavior. This endeavor is complicated in a society that shows minimal concern about television violence for children, for example, but may overreact to nudity or depictions of nonheterosexual behaviors.

The purpose of this article is to place the sexual interests and behaviors of children and adolescents into context; the focus is on actual behavior rather than fantasy. Focusing interventions on fantasies would probably create considerable clinical difficulty. The emphasis will be on postpubescent minors. We hope to provide practitioners with an approach to understanding these acts within the larger developmental processes. Because of the enormity of our task, we do not discuss children or adolescents who display unusual forms of gender expression, gender nonconformity, or report gender dysphoria.

### **Child and adolescent sexuality in historical context**

What is judged as “normal” and “unusual” sexual behavior is highly variable and dependent on social and cultural contexts. These sociocultural views ascribe

meaning to sexual behaviors, and, therefore, shape the child's and adolescent's experience. The linking of sexual development priorities to appropriate sexual behaviors for children and adolescents could not transpire until the social category of adolescence was invented. Before this change, adolescents were treated as adults by society [3].

For most of human history, children participated in adult social and economic life and shared single-room homes that exposed them to adult sexual conversations and behaviors. Within this context, the prevalent expectation was that adolescents were to be sexual and reproductive from an early age. By the late sixteenth century, the meaning of childhood and adolescence had shifted. Childhood was construed as a particular stage with developmental priorities that were related to sexuality. Children were perceived to be fragile, weak creatures that needed protection from the vicissitudes of adult sexuality. The romantic conception of the “innocent” and “asexual” child who required protection from adult sexuality blossomed during the Victorian era. The notion grew that masturbation caused insanity and that it was necessary to suppress sexual appetites. Previously, sexual restrictions were justified on moral and religious grounds; however, during the Victorian era medical rationales for sexual suppression began to predominate. Public concern about the sexual habits of children and adolescents became significant to society and were scrutinized increasingly by parents and religious, medical, and legal authorities [3]. The meanings that were ascribed to child and adolescent sexual development and behavior during this period continue to inform our beliefs about children as being sexually “innocent” and as adolescence as a period that requires sexual constraint.

Since the beginning of the twentieth century, the meaning of childhood and adolescent sexuality has remained highly contested [4]. Children and adolescents must sift through mixed messages that sexuality and sexual behavior are dangerous and pleasurable. Children are told that sexuality is dangerous and predominantly is linked to social problems, teenage pregnancy, and sexually transmitted infections (STIs); conversely, they are told that sexuality is a source of personal fulfillment and pleasure. Clinical wisdom about psychosexual development must be situated in this historical context and recognize that what constitutes acceptable sexual expression among children may be influenced by political, social, and moral prerogatives or romanticized by the notion of childhood “innocence.”

### **The sexual interests of prepubescent children**

Sexual behaviors are typical of children at almost all ages—certainly after infancy—although they require definition relative to age and to a specific child. Prepubescent children do masturbate and have orgasms, although boys do not ejaculate. Childhood “sex” play probably is motivated more by curiosity than by sexual desire. Thus, dimensional qualities of temperament, personality, and cognitive potential play a role in sexual behaviors, whereas psychiatric or other

organic illness or social conditions may have sexual ramifications. Any clinician, therefore, must find perspective in a given child's unusual sexual behaviors or reactions to any social and clinical circumstances. Apparent absence of sexual interest or muted sexual behaviors are atypical. Intense sexual behaviors may be associated with comorbid conditions (eg, disruptive disorders) or primary psychiatric illness; these conditions must be entertained and require assessment and intervention that targets the sexual behaviors. These conditions are beyond the scope of this discussion.

Additionally, most parents and clinical professionals are poorly versed in typical psychosexual development in children—at least until experience intervenes and possibly educates. Thus, perspective is important; sexual behaviors may be unusual in one circumstance and fairly typical in others. Alleviating the anxieties of parents or other adults may be a significant goal of clinical interventions. Additional goals of interventions for unusual sexual behaviors, however, must include prevention of dangerous behaviors, mitigation of family concerns or conflicts regarding sexual behaviors, encouragement of healthy psychosexual development, and alleviation of child anxieties about sexual feelings, fantasies, or expression.

### **Healthy sexual interests among adolescents**

Despite few data about what constitutes normal sexual interests among adolescents, we accept that healthy adolescents are interested in sexuality, have sexual desires and fantasies, and that most will masturbate. Typically, it is presumed that these interests will be heterosexual, coital, and eventually will lead toward monogamous relationships and marriage. There is considerable fear that if teens act on their desires, the results will be STIs, unintended pregnancies, and moral decay. Many people believe that mentioning sexual options or allowing for any sexual activity will encourage sexual experimentation [5].

There is little appreciation that sexuality can potentiate positive experiences in the lives of teenagers and even less is done to make sex growth-affirming for them. Young boys may be made to feel ashamed of their ease in getting erections. Young girls may learn to feel that their sexual desires are dangerous and must be constrained [6]. Sex counseling and therapy are contemplated rarely for dealing with the sexual dysfunctions that adolescents might experience. Anecdotally and clinically—premature ejaculation in adolescent males and anorgasmia in adolescent females are common.

Teens are expected to control their sexual conduct without being told how to manage their desires; however, willpower and the proverbial cold shower rarely are effective. Adolescents, particularly girls, are bombarded with messages that tell them to be sexy without being sexual. The resources that are available to adolescents to deal with their conflicts are abysmal. Frequently, sex education courses are based in abstinence-only curricula (see later discussion) or classes that focus on reproductive biology, with birth control and STI prevention added. Truly comprehensive sex education is rare in the United States.

Sexual behaviors that are viewed as unusual depend on the age and sex of the teens involved. Boys are expected to be more sexual and more dangerous sexually. Sex offenses that are committed by girls (and women) often are ignored or minimized; erroneously, girls are not even considered to be possible perpetrators [7]. Paradoxically, when girls are sexually active in ways that some people consider normative for boys (eg, with multiple partners), peers and authority figures may denigrate them.

### **Legal versus illegal and immoral sexual acts**

Whether a sexual behavior is deemed illegal depends on the jurisdiction in which it takes place [8]. Reputable psychiatrists cannot suggest or condone that minors engage in illegal acts or acts that seem to be illegal. Historically, it is evident that some behaviors are not deterred by legal constraints. Whether a sexual act is legal or illegal, morality is a separate issue. Again, reputable psychiatrists may have difficulty with suggesting or condoning behaviors that violate their own moral codes or the prevailing morals of the community. Concerns in this area cannot be ignored.

Forty years ago, psychiatrists typically discouraged homosexual youths from exploring and coming to terms with their sexual desires. The stigma and alienation of that time were reinforced by long bouts of psychotherapy that were intended to “cure” homosexuality. When homosexuality was removed from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), programs emerged to support homosexual teens, rather than to convert them to heterosexuality. We expect that other sexual interests (eg, fetishism, sexual sadism, sexual masochism) will be re-evaluated in the coming decades as the prevailing moral climate continues to change [9–12].

We believe that the best advice for the practicing psychiatrist is to recognize when one is depending primarily on moral beliefs and when science provides the guiding principles. Cynicism toward the latest fads always is warranted; conventional “wisdom” often is wrong. Pronouncements that sound logical today may not be in the best interests of the patient. To avoid such pitfalls, psychiatrists are advised to seek expert sources or supervision and to examine their own visceral clutch for the possibility of countertransference reactions.

### **“Normal” versus “unusual” or “abnormal” child and adolescent sexuality**

The term “unusual” implies that the sexual activity in question falls outside of an expected range of sexual behavior for the specific age groupings or gender role norms; typically, a negative connotation is associated with the term. Children who refrain from exploring their sexuality or limit their sexual interests to social ideals are not considered to be unusual. Sex is one of the few domains in which being more “adult” or precocious is considered a liability.

The assessment of unusual sexual activity invokes similar implicit assumptions about what constitutes normal sexual development. A practitioner's sense of what constitutes normal or unusual sexuality is influenced by clinical theory, empiric research, personal experiences, socialization, and cultural and religious backgrounds. The evaluation process remains highly subjective, with consensus in only extreme cases.

### **Can a minor be diagnosed with a paraphilia?**

The *Diagnostic and Statistical Manual of Mental Disorders, Revised Fourth Edition* (DSM-IV-R) indicates that paraphilias may begin in childhood but are manifest in adolescence and early adulthood [13]. Nevertheless, there has been ongoing, serious criticism of the diagnostic category of the paraphilias through several editions [10–18]. Unquestionably, there are people who suffer or bring distress to others because of their unusual sexual proclivities. Some describe their lack of control over sexual feelings, thoughts, or behaviors. The question is not whether such individuals exist but whether the construct of the paraphilias as described in the DSM is the best way to conceptualize their problems. Some of the major objections to the paraphilia category are:

It is difficult to diagnose sexual psychopathology when scientific definitions of healthy and pathologic sexual behavior continue to elude us.

The objectivity that is required by the DSM can be compromised when diagnoses are based on atypical sexual behavior, given that such behaviors tend to evoke volatile social reactions.

It is hard for clinicians to disentangle themselves from the sociocultural context in which the diagnostic process occurs.

The history of the DSM indicates that sexual disorders sometimes were included or excluded (eg, homosexuality, nymphomania, hyposexual desire disorder) based on changes in social values more than because of the introduction of new evidence.

There is no empiric data to prove that these behaviors, per se, create distress or dysfunction in adults.

The distress or dysfunction that is associated with unusual sexual behavior may be caused by stigma or discrimination and may be alleviated by social support rather than treatment of any mental disorder.

The term “paraphilia” is often used to describe obsessional, compulsive, or impulsive sexual behaviors, although these terms are not part of DSM diagnostic criteria for the paraphilias.

The criticisms of the paraphilias as a diagnostic entity are even more serious with respect to minors. Although it is true that many individuals who are diagnosed with paraphilias recognize that their interests began in childhood, it is not clear how many who had unusual interests in childhood abandoned or

changed those interests by adulthood. Significant caution is warranted in applying the diagnosis of a chronic disorder with considerable negative and long-term implications to children and adolescents. The recognition of unusual sexual behavior in childhood, without labeling it as pathologic, may allow time to focus the expression of that behavior in a prosocial manner.

### **Defining unusual sexual interests**

We do not want to repeat the mistake of identifying specific, unusual sexual behaviors as pathologic, particularly without the data to substantiate such classifications. Naming and classifying particular, unusual behaviors allows for the inference that other, unclassified (ie, more or less common) behaviors are unlikely to be the source of difficulties. For the purposes of this article, unusual sexual interests are discussed in terms of the following considerations.

#### *Frequency of sexual behaviors*

The definition of hypersexuality in adults or even if this phenomenon exists continues to be debated in the scientific literature [19–21]. Psychiatry has failed to create meaningful definitions of promiscuity, nymphomania [19,22], hypersexuality [20,21], or similar concepts, despite decades of attempts. The latest attempts to redefine “nonparaphilic hypersexuality” [23,24] and, especially, “sexual addiction” [25,26], are more popular with the lay press than they are founded on empiric scientific data. For minors, the problem of classification or “diagnosis” is significantly more difficult because normative frequency data for different age groups do not exist.

It is likely that masturbation is the most common sexual behavior among minors [27–29]. Adolescents often are conflicted about masturbation; they learn that it is morally wrong in most religions but have difficulty in refraining from such a pleasurable behavior. Nevertheless, masturbation may look and feel like a compulsive behavior to the adolescent who is “ravaged” by desire. Despite this, most adolescents outgrow the apparently “compulsive” aspects of self-stimulation as soon as partnered sex is available to them. Partnered sex usually does not have the same “compulsive” aspects to it. Nevertheless, many healthy teenagers seem to have a stronger interest in sexual activity than does the average adult.

Sometimes unusual and even “unhealthy” sexual behavior may be understood better from the adolescent’s perspective. Manzar [30] discussed the case of a Muslim male who had frequent urinary tract infections that resulted from masturbation with prevention of ejaculation by back-milking movements of the penile shaft. This unusual and unhealthy masturbation method—that is intended to prevent seminal expulsion—was adopted to conform to religious teachings. The solution may have been problematic but it allowed him to pray and masturbate. This case illustrates how a behavior can seem to be compulsive and unhealthy, but may be adaptive for the adolescent. It is easy to imagine other,



more dangerous sexual behaviors that would require intervention; however, how one defines “dangerous” and “unhealthy” is subjective.

Any activity can become “compulsive.” Teens are notorious for becoming “overly” interested in a particular activity for a time, often to the exclusion of other pursuits. One can conceive that sexual preoccupation can be one of the competing interests that displaces others during adolescence.

### *Difficulties controlling sexual expression*

Children know that some activities should take place in private (eg, defecation) and that others can occur in the presence of others. Failure to keep sexual activities private may suggest a problem; however, children and adolescents may not have access to an appropriate setting or time for sexual activity. For them, that does not extinguish desire nor does it signify that the only option is abstinence. Under those circumstances, it is important to ascertain the intention and preference of the child. Some unusual sexual behaviors may be controlled or eliminated just by allowing the child privacy.

Surreptitious and exhibitionistic acts should be evaluated differently. The fact that a young person was observed or caught engaging in sexual activity does not mean that the child or adolescent wanted to be seen or found the behavior erotic. Furthermore, exhibitionism can exist with consensual or nonconsensual observers; this can be a crucial distinction. A desire to elicit a fearful reaction is different than a desire to be found attractive. The adolescent who finds the possibility of being caught arousing should not be confused with the one who is hoping to avoid discovery.

Sexual interests that become so overpowering that they interfere with other functions (eg, school or friendships) are of concern. The “interference with functioning” is at the core of the DSM definition of a mental disorder. Conversely, the absence of an acceptable outlet for sexual activity also may interfere with a child’s functioning. Sexual activity that the child cannot or refuses to limit to socially acceptable times and locations (eg, self-stimulation) also is considered unusual or problematic. In other cases, the problem is not primarily sexual; the expression of the problem may be sexual (eg, engaging in sex with numerous partners may be related to depression). In our experience, focusing unduly on the sexual component is unlikely to bring about a satisfactory resolution. If distress or dysfunction appear following discovery of the sexual activity, the cause of the distress may not be the sexual interest but, rather, being discovered. A simplistic notion—for example, if the teen were to abandon the unusual behavior then the distress would be eliminated—rarely is true. It also is unwise to try to suppress sexual interests entirely. Disconnecting adolescents from their own sexual feelings can create future sexual difficulties. The individual may not be able to reactivate sexual desire when it is deemed socially appropriate; this is deemed “hyposexuality” in adults. Adolescence is a time for exploration of identity, interests, and desires, including sexual ones. Sexual dysfunction may be less frequent among adults who are raised with sex-positive messages.



### *Consent*

Among individuals of all ages, one criterion for healthy sexual expression is that it is mutually consensual. Although issues of consent are more ambiguous among children and adolescents, how minors feel about consent and ascertain consent with their partners are important in the assessment of unusual sexual behaviors. Patterns of behavior are of greater concern than individual incidents, even if serious. Among adults, misunderstandings abound and often have serious consequences. Teenagers often have the added handicap of lack of privacy or of a suitable location and may try to negotiate these issues while experimenting with drugs and alcohol. Individuals who have difficulty limiting their sexual activity to consensual partners are likely to suffer from more than just sexual behavioral improprieties.

### *Nonheterosexual interests*

Traditionally, major developmental theories have suggested that healthy development eventuates in heterosexuality, and, primarily, acts that could result in reproduction. Noncoital interests often are judged as unusual, immature, or even pathologic. These acts have many motives, including experimentation, peer pressure, curiosity, or even attempts at birth control. Peers may exert extreme pressure for adolescents to engage in sexual acts that have no erotic interests for them. It is important to discover the motivation of the minor before assuming that the individual has a sexual concern.

Mental health professionals often want to avoid mislabeling adolescents as homosexual to prevent the stigma that often comes with that label in our society. It also allows us to acknowledge that some adolescents will “outgrow” this attraction. Sexual orientation may be more fluid than commonly is believed; sexual behaviors can be extremely fluid. We have little concern for mislabeling youth as heterosexual, although that, too, might create future difficulties. Homonegativity (dislike of or hostility toward homosexuals and homosexuality) might lead adolescents to explore heterosexual acts, even if they prefer same-sex partners; reject sexual activity; or act out aggressively against those who are perceived to be homosexual. Internalized homonegativity can be an important element in the increased suicide rate among gay/lesbian/bisexual youth [9].

There is a wide variety of sexual desires other than for conventional, heterosexual activities. Teenagers are experimenting with many new behaviors and sexual interests. Sadoomasochistic activities, group sex, cross-dressing, fetishism, the use of sex toys, and so forth may be more common than supposed. In many adolescents, such behaviors might be transitory; however, a few behaviors become enduring parts of a given individual’s sexual pattern.

### *Sexual interests in much older or younger partners*

Concerns about sexual abuse and predatory sexual behavior are prevalent in our society. Older children, by virtue of their greater size and social skills, can

coerce younger children into sexual activity while believing that they are engaging in consensual activities; younger children often believe that they cannot disobey someone who is older. In addition, there is some concern that children who engage in sex play with other children will become fixated on partners of that age.

It also is possible that a younger teenager will use sexual activity as a way to develop a relationship with an older teen or be seen as part of the “in-crowd.” Sexual activity can be seen as a rite of passage—an entry point into adulthood—and as an initiation rite for admittance to a desired group; this can be motivated by their own sexual desires and attempts to gain status with their peers.

### *Sexual interests that incorporate atypical sexual stimuli*

Discovering a 15-year-old male masturbating to pictures of adult female is not surprising; discovering the same boy masturbating to pictures of male or female feet would more likely lead to a referral to a physician or mental health care provider.

There clearly is cause for concern when sexual fantasies incorporate behaviors that lead to or risk physical injury. Masturbation with sandpaper is of greater concern than masturbation with a silk scarf. Teenagers are much more likely to be injured from sports participation or motor vehicle accidents than by unusual sexual activities. Sometimes, the object that is incorporated in the sexual play or how it is used creates alarm. The insertion of a perfume bottle in an orifice usually has more to do with the shape of the bottle than a sexual interest in a particular scent.

### *Number of partners*

Our society is based upon the ideal of monogamy, despite high rates of nonmarital sex and divorce. Adults in our society who indicate that they are polyamorous (ie, able to love more than one sexual partner at a time) are treated with derision or regarded askance, as if they are too immature for a committed, intimate relationship. In adolescence, the opposite often is the ideal. Parents become concerned when the couple “goes out” together for too long and worry that the couple may experiment with sexual activity or move on to marriage too quickly. Adolescent girls who date different boys may be seen as “sluts” or as too interested in sex, even if they refrain from sexual activity. Adolescent girls often are in precarious, no-win positions. Boys who date “too much” are seen as lucky, as unable to make relationship commitments, or as just using girls for “what they want.” There is concern that boys who do not date are social misfits, homosexual, or have other problems. Girls who do not date are perceived as being “ugly,” immature, lesbians or as having some other difficulty.

### *Sexual abuse*

Some children are forced to engage in sexual acts by persons who are older or much stronger. Typically, children have little understanding of the meaning of

these acts, how they are being victimized, and the implications of their “participation.” Even when minors believe they are participating with an adult or a much older child willingly, there cannot be informed consent. Depending on the perpetrator’s tactics, some children find the genital contact or the seemingly affectionate attention “enjoyable” at the time, some are traumatized by it, and some may be ambivalent about the experiences. Signs of sexual abuse include fearful reactions when sexual topics are raised, vaginal discharge, and the occurrence of odd and age-inappropriate toileting behavior [31]. After the sexual abuse is made public, the child may be seen as suspect, shunned by peers, or judged by others. One fear is that they have been “sexualized” or “damaged” and will continue to act out the trauma. Psychotherapy should be offered for the child and family as should guidance for teachers and other caregivers. Children should receive information on the difference between sexual coercion and appropriate sexual expression and the meaning and role of consent. Feelings of guilt, shame, and of being defective must be explored and alleviated.

### **Dangerous sexual behaviors**

Dangerous sexual behaviors are various and potentially extensive in scope and might be considered unusual behaviors by fiat; they are discussed only briefly. Such behaviors include danger to self and danger to others. Boys, especially pubescent ones, are overrepresented in this category. Self-danger most commonly involves placing objects or instruments into, or circumscribing, the genitalia or placing the penis into a dangerous object. Preschool girls may place foreign objects (eg, crayons, peanuts) into the vagina; this is a more unusual behavior in older girls, presumably because of the greater cognitive recognition of risks or other social implications. Early school-age boys may tie something around their penis; pubescent boys may place objects into the urethra (and occasionally lose them). In these cases, a urologist and a psychiatrist or psychologist may provide important liaison functions for the pathophysiologic ramifications of such behaviors and for a determination of psychosexual developmental atypia or unacceptable levels of further risk. More longitudinal assessment and observations may be important; interventions most commonly involve parent-patient education.

Sexual behaviors that are dangerous to others—sexual predation by one child toward others—require a more involved assessment by an experienced psychiatrist or psychologist. Liaison with a pediatrician or a pediatric urologist is important. Other important factors and perceptive recognitions include the relative ages of the predator to the recipient, the level of sexual intimidation, and the degree of sexual maturation of the offending child. It is important to recognize sexual impulse control problems (especially in the adolescent) while providing education and structure for parent-monitoring for both children. Education and other cognitive approaches also may be useful to a pubescent child for improving self-monitoring. Clinical experience in a Psychosexual Development Clinic found that similar sexual experiences among children may

have clinically significant psychosexual ramifications for some children but not for others; girls may exhibit higher overall risks (for example, see ref. [32]).

### **Anxiety-provoking sexual behaviors**

Some sexual behaviors are unusual in that they create anxiety in the parent (or other adults) or in the child. Accidental or intended exposure of the child to adult sexual intercourse may create anxious reactions in the child or anxious responses in the parent. Additionally, sexual behaviors by themselves, especially exhibited by the younger preschool child, may provoke anxiety in the parent and reactive anxiety in the child. Exposure to pornography may create similar clinical pictures as can sexual experiences with other—particularly older—children. Generally, parent monitoring, and parent and child education or other psychoeducational techniques are useful. Longitudinal assessment may be of benefit.

Some unusual sexual behaviors require interventions because they are illegal or offensive. Again, preadolescent and pubescent boys are overrepresented. Brief, but recurrent, exhibitionism is not an uncommon behavior in preadolescent boys, especially those in the 10-to 12-year-old age group. Such behaviors generally occur outside the family and tend to offend other children's parents. Persistent and more directed exhibitionism, generally in the mid- or late adolescent, is a rare occurrence that often is discovered by a child's parents when he is arrested; it can have serious legal consequences. The origin of such behavior is unclear; interventions may not be of great benefit.

Sexual behaviors that generally are known as fetishes often are first recognized by parents or an older sibling. These behaviors are complex and commonly involve erotic stimulation or imagery by the stealing of or wearing female undergarments or clothing; these behaviors are brought to clinical attention when a boy reaches about 11 or 12 years of age. Signs of unusual sexual interests at younger ages may be related to obsessive–compulsive-like phenomenology; in rare circumstances, these may respond to interventions that are aimed at the underlying obsessive-compulsive phenomena. More typically, however, such behavior responds only to educationally-oriented approaches to down-play the behaviors and protect the child from discovery while protecting members of the household from conflict or embarrassment in family dynamics. These behaviors are complex in nature and are difficult to inhibit.

### **The role of the clinician**

Generally, unusual sexual behaviors respond well to cognitive, educational approaches for parents, patient, other adults, or a combination of these; therefore, these interventions generally are strongly goal-oriented and brief in duration. When the operative drive is erotic, however, short-term goals may be ineffective. Support groups may benefit some parents or children in these situations. Pro-

viding longer-term sexual therapy to the child that assists him in bridging his erotic drive to be more nearly acceptable (or “normative”) can be useful and important; however, bridging techniques are likely to require intermittent and sometimes frequent reinforcement. If legal offense is likely—as in exhibitionism in the late adolescent—clinician-reporting before the child has offended generally is considered to be unethical, illegal, or both; generally, legal institutions have no recourse before an offense is committed. Continued involvement of the clinician can be important after the child has offended. In such conditions, protection is difficult for the potential offender or for those who are likely to be offended against. The clinician must be persistent, firm, and judgmental of behaviors but not reject the child him/herself.

### **Sexual silence**

Most typical adolescents attempt to be discreet about their sexual conduct. For adolescents who have concerns about their sexual interests, the prospect of confiding in an adult can be a daunting prospect. It is even worse for those who have kept their predilections secret but are discovered, especially if their sexual behaviors are unusual. For adolescents or children who have been identified as having psychologic problems (or especially sexual problems), it often is more difficult to keep their interests secret because these minors are scrutinized more closely; therefore, it is less likely that their behavior will go unnoticed. This may be one reason why there seems to be an association between youth who are diagnosed with psychiatric problems and so-called, but commonly undefined “sexual acting out”; more attentive (or perhaps intrusive) surveillance is more likely to uncover private behaviors. Additionally, any provider who assures minors that they can confide freely about any thoughts or behaviors needs to be capable of “handling” that adolescent’s disclosures.

### **Sex education or more silence**

There is a great deal of controversy about sexuality education in American society. Abstinence-only sex education is the only approach that is funded by the federal government. This is aimed at convincing teens not to engage in sex. Such curricula sanction teaching questionably accurate “facts” (eg, condoms are ineffective, any sex will lead to pregnancy and disease, and the inability to refrain from sex indicates moral weakness or psychologic problems). Under abstinence-only sex education guidelines, the only statement that high school teachers in Anchorage, Alaska can make to students about masturbation is: “Masturbation, though no longer considered harmful, is a practice which some groups you may belong to do not condone” [33]. A minor improvement from abstinence-only sex education is abstinence-based sex education, which consists primarily of abstinence-only sex education plus some birth control and STI

prevention information. Neither of these approaches adequately prepares teens to understand the range of sexual options that are available or to grapple with the sexual issues that face our society or that they will face (eg, gay marriage, the meaning of the Clinton/Lewinsky affair). Unwanted pregnancies and STI rates are used to evaluate the success of sex education programs; these are questionable measures of an academic program. Research demonstrates that abstinence-only programs have failed [34–36] in the prevention of teenage pregnancy and STIs and in the preparation of adolescents to navigate sexual challenges. A special issue of SIECUS Reports [37] described the adverse impact of abstinence-only sex education on American adolescents (in their own words).

An alternative is comprehensive sex education, which emphasizes broad-based knowledge of all aspects of sexuality and enables students to make informed decisions about sex. In addition, it incorporates discussion of sexual feelings and desires; risk-reduction strategies; and rehearsal of relationship, communication, and negotiation skills. Research indicates that these programs are significantly more effective in delaying sexual activity and in reducing STIs and unwanted pregnancies [38,39].

Sex education could have an invaluable role in guiding children toward respectful, responsible, and mutually-fulfilling sexual relations. When government severely restricts sex education in the United States, teens who have been kept largely sexually ignorant are ill-prepared for the possible consequences of engaging in sex. As a corollary, whether current sex education programs affect the prevalence of unusual sexual behavior, they are likely to isolate children who have such concerns and to impede counseling or consoling for them.

### **Sexual meanings in childhood and adolescence**

Despite the concerns of society and parents, children do engage in sexual acts alone as well as with others. Some adults think that positive discussion about sex will lead to inappropriate and premature experimentation. Others suggest that the lack of honest and clear information leads to an increase in unusual [40] and unsafe sexual practices [41]. Although we have little data in regards to these claims, it is important to give positive sexual messages to children and to avoid associating sexuality with shame. Guilt-laden or anxious reactions to childhood sexual conduct may be more problematic to the child and adolescent than the actual behaviors [42].

In general, typical children seem to experiment with many different sexual behaviors during childhood and adolescence. An adult's focus on a particular behavior may have undesirable effects. Prohibitions may focus interest on the forbidden. Thus, adult admonitions may play a pivotal role in determining whether sexual experimentation remains exactly that or becomes more entrenched developmentally.

Socially, behaviors that are illegal, nonconsensual, or dangerous need to be discouraged. This may be accomplished best by giving the child or adolescent

more options. It is much easier to replace the thought of a pink elephant with a blue tiger than with a directive not to think. A common, dangerous sexual behavior among adolescents is unprotected coitus. The solution to this problem lies in educating young people about the risks of unprotected, penetrative sex and teaching them about abstinence and safer sex. Ironically, the American reluctance to confront this problem openly and directly highlights the difficulty that parents, schools, and psychiatrists face in dealing with atypical sexuality in children and in suggesting appropriate, alternate forms of expression.

### **Sexual behavior for “nonsexual” purposes**

Adolescents may use their sexuality for purposes other than sexual pleasure. By being seductive or overtly sexual, they may gain peer status; access the adult world; obtain possessions (eg, clothes or money) or the feeling that they are valued, powerful, and in control. This process risks placing adolescents in the position of being exploited and entangling their self-worth with the willingness to exchange sex for other commodities. Similarly, children may be drawn into sexual activities that are unrelated to their own sexual interests. This occurs when they are victimized, such as in child pornography, prostitution, and other sexual abuses. Sex work is one of the few ways in which minors can be financially independent and escape other abusive situations.

Illicit drug use—procuring or imbibing—also can be a motive for sexual activity. For example, the sale of sex can fund drug procurement. Furthermore, some drugs decrease inhibitions and internal resistance to the activity itself. Sorting out the more important of these motivated behaviors can be elusive. Additionally, the lowering of inhibitions may or may not reveal an individual's actual sexual interests. At least among adults, there are individuals who have no interest in their atypical sexual acts when sober and drug-free.

A variety of developmental or psychiatric problems also can lead to unusual sex practices. A depressed teenager may escalate the level of sexual activity to find something that relieves psychic pain. Other teens who have poor judgement may believe erroneously that they can perform unusual and risky behaviors safely. Working with these teens to deal with the underlying problems may mitigate unusual sexual behaviors.

### **What do we know about the genesis of unusual sexual behavior?**

How individuals develop their unusual sexual interests is not known. It is clear, however, that children develop—or at least possess—sexual interests. These interests may wane, evolve, or be integrated into adult sexual patterns. From our clinical experience, most adults and teenagers who engage in unusual sexual behavior recognize that their desires were present in early childhood. Sometimes, parents recognize early patterns of such behaviors retrospectively. When con-



fronted with the recognition that one has an unusual sexual interest, some individuals attempt to extinguish their arousal patterns, whereas others embrace them. We do not know how people develop sexually or what leads them to accept or reject their own patterns.

### **The role and impact of sexual abuse**

A prevalent and typical assumption in the literature is that unusual sexual behaviors are caused by child sexual abuse [43–47]. The data to support this statement are lacking and many other possible explanations exist (eg, family dynamics, genetic predispositions, lovemaps) [48]. Additionally, our clinical experience negates generalizing the assumption that unusual sexual behaviors are caused by sexual abuse.

There is much concern that those who have been abused will abuse others [49–52]. Only a small percentage of individuals who have been victims of child sexual abuse victimize other children [53,54]. Causation is unclear regardless of findings; valid study methods are unavailable. The literature also suggests that child sexual abuse inevitably causes sexual dysfunctions or other psychiatric sequelae [55–58]. The assertions are that the abuse itself, as well as the resulting intrapsychic and interpersonal difficulties, can lead to various sexual problems and concerns that become apparent in adolescence and adulthood [55–60]. These problems include aversion to various body parts and sexual acts; feelings of being “dirty”; poor body image; difficulties with trust and setting sexual boundaries; sexual orientation confusion; difficulty initiating or declining sex; withdrawal; feeling emotionally empty; and sexual dysfunction [55–61]. Epidemiologic follow-up with valid study methods is lacking. Clinical experience seems to refute that such outcomes are inevitable.

Although a history of sexual abuse may be correlated with unusual sexual behavior, it does not necessarily follow that it is the consequence or that unusual sexual behavior is caused by sexual abuse. Clinicians should assess for a history of sexual abuse when a child is referred for unusual sexual behaviors (or other psychiatric problems) just as they should assess sexual activities. If abuse has occurred, it is prudent to deal with psychologic consequences and their impact on sexual expression rather than targeting any unusual sexual conduct in isolation.

### **Research on normal and unusual adolescent sexual behavior**

Research on normal adolescent sexual behavior has been problematic; typically, the primary focus has been on behavioral events, such as age at first intercourse, contraception, and sexually transmitted disease. Such focus inevitably imbues findings with negative meanings [62,63]. Questions about unusual or noncoital behaviors and fantasies in normal adolescent populations are ignored

[63]. Given the current politics of sex research and the sex-negative attitudes of American society, it is difficult to imagine that any researcher would receive funding or approval to conduct a large-scale, descriptive study of childhood sexual desire and expression.

Most adolescents engage in sexual behaviors—whether with partners or alone—at least occasionally. Sexual experimentation in adolescence can provide a platform for rehearsal of future adult sexuality. Most adolescents do not have access to sexual information that would allow them to decide which sexual behaviors that they would be most interested in exploring. Rather, they experiment with what is available, sometimes with amusing results. In 2002, the Harry Potter vibrating broomstick was sold as a toy primarily for prepubescent children; however, it quickly became a favorite masturbation device among teenage girls. Parents complained and often removed the batteries, but there is no indication that they used the opportunity to discuss masturbation with their children [64]. Children and adolescents experiment with sensations and noxious stimuli that adults often find unpleasant (eg, roller-coasters). It is not surprising that their sexual explorations can be unusual.

### **Unusual sexual interests and concurrent psychiatric concerns**

Underlying psychosexual development may effect, and be affected by, unusual sexual interests. For example, in children who have unusual sexual interests, underlying impulse control difficulties may stimulate, or be stimulated by, sexual interests. Yet neither impulse control nor unusual sexual interests necessarily is a sign of enduring pathology. Focusing interventions on the more readily treated problem may help to resolve the other.

Lack of impulse control, however, may be important in differentiating at least some individuals who have unusual sexual interests and are likely to commit sexual offenses [65]. There are individuals who have unusual sexual interests who never acted upon them or never act upon them inappropriately. Differentiation between sex offenders and nonoffenders seems to be linked less likely to sexual content or sexual ideation than to the impulse dyscontrol or social deviance [66]. We do not understand what leads some persons to be able to control their impulses while others cannot.

Adult sex offenders often are diagnosed with Antisocial Personality Disorder. Similarly, Conduct Disorder, seems to be the most prevalent diagnosis among adolescent sexual offenders [64]. According to DSM-IV-R criteria, to be diagnosed with Antisocial Personality Disorder requires being diagnosed previously with conduct disorder. Nevertheless, most persons who are diagnosed with conduct disorder are not diagnosed later with Antisocial Personality Disorder [13]. This implies that adolescent sex offenders will not become adult sex offenders necessarily.

There is some evidence to suggest that social conditions are linked with psychiatric symptoms in children; improvement in social conditions can amelio-

rate psychiatric presentation. In one study, exiting from poverty significantly decreased the incidence of symptoms that were associated with Conduct and Oppositional Defiant Disorders to the level of those who never had been poor [67].

A negative parental or social focus on the unusual sexual behavior itself also may be an issue for children. Typical psychosexual developmental patterns—or pitfalls—in these children are unclear. As has been demonstrated with gay and lesbian youth, however, teens who can find a community of others who share their interests may fare better psychosocially than those who are isolated [9,68,69]. Adolescents who find positive information about their sexual interests may fare better than those who are believed to be psychiatrically ill.

## Summary

Our understanding of unusual sexual interests in children and adolescents is in its infancy. This article attempts to position the topic in its overall context. Social and legal proscriptions may have a greater impact on how clinicians regard unusual sexual behavior than does knowledge. Defining unusual sexual behaviors is complex. Determining individuals in whom the behavior will endure or become worrisome is a further challenge for issues of social safety as well as for clinical intervention. The literature on unusual sexual interests tends to focus on adolescent sex offenders—a selection bias of social safety. Yet this approach has not been beneficial for an understanding of the nature of unusual sexual interests themselves or of which behaviors require clinical—as opposed to legal—interventions. We do not know why or how some children become interested in unusual sexual expression. We do not know which individuals will “outgrow” these interests or in whom they will endure. We do not know when such behaviors need to be treated or the effects or the efficacy of such treatment interventions. Rational interventions are difficult to formulate before the recognition of relevant phenomenology. Additionally, interventions for unusual sexual behaviors in children and adolescents have potentially profound and lasting social and legal effects; however, parental and social approaches to children who have unusual sexual behaviors are neither rational nor consistent. Sex education programs in the United States suffer from a similar design that is not rational.

We are in need of comprehensive studies of child psychosexual development and outcome. We also would benefit by educating our parents, educators, legislators, and health-care providers about child sexuality—and what we do not know about it. Therefore, current clinical approaches to unusual sexual behavior in children and adolescents are misguided. Future research must consider our paucity of outcome data and cultural factors (eg, gender, socioeconomic factors, and sexuality-biases) in investigating unusual sexual behavior. Mental health professionals need additional information to make more effective assessments and clinical interventions.

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