Unwanted Intrusive Thoughts of Infant-Related Sexual Harm:

Prevalence and Assessment of Safety

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Abstract

Objectives: Unwanted intrusive thoughts (UITs) of intentional infant-related harm are common among birthing parents. Evidence to date has failed to find any association with physical aggression toward the infant. However, the relationship between UITs of infant-related sexual harm and sexual behaviors toward the infant has yet to be assessed. This is the purpose of the current study.

Methods: Data were collected from February 9, 2014, to February 14, 2017, via a prospective, province-wide, unselected cohort of N = 763 English-speaking birthing parents, n = 502 of whom provided data for the current analysis. Interview assessments of UITs of infant-related sexual harm were administered at approximately 7 weeks postpartum and 4 months postpartum. Sexual harming behaviors toward the infant were assessed via an anonymized questionnaire at the end of the study.

Results: UITs of infant-related sexual harm were reported by 9.2% (n = 38; 95% CI, 6.6–12.4) of participants. We found no evidence of an association between UITs of this nature and sexual behavior toward one's infant (Fisher exact, $P = 1.00$). Only 1 participant reported engaging in sexual behavior toward their infant, and they did not report any UITs of infant-related sexual harm.

Conclusions: Study findings add to growing evidence that UITs of infant-related harm are common, and when these thoughts are unwanted and intrusive, they are not associated with an increased risk of actually harming one's infant. Although findings suggest that this is also true for UITs of infant-related sexual harm and sexual behavior, due to the small sample employed in this research, replication with a larger sample is needed.

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Unwanted intrusive thoughts, images, and urges (UITs) of infant-related accidental (eg, "What if I trip while carrying my baby?") and intentional ("What if I step on my baby on purpose?") harm are common among new parents, with most (99%) experiencing UITs about accidental harm and half (50%) also experiencing UITs of harming their baby on purpose.[1]

The content of UITs of intentional infant-related harm typically involves verbal or physical aggression, sexual touch, or abandonment of one's infant. Not surprisingly, parents experience UITs of intentional harm as more distressing than UITs of accidental harm.[1] Among vulnerable individuals, UITs of infant-related harm can lead to mental health difficulties, in particular obsessive-compulsive disorder (OCD, an anxiety-related disorder).[2] Negative misinterpretations of the meaning and frequency of normally occurring UITs to mean an individual is responsible for causing or preventing negative outcomes can lead to their development into obsessions.[3] Individuals will engage in compulsive behaviors in hopes of reducing the associated distress and the likelihood of the feared negative outcome from transpiring.[3] In contrast, extant evidence fails to support an association between these thoughts (or OCD) and any increased risk of harming one's infant.[1,4] In a sample of 100 birthing parents, similar proportions of participants who did (28.2%) and did not (27.5%) experience UITs of intentional infant-related at 4 weeks postpartum had engaged in a harsh parenting behavior.[1] Similarly, in a sample of 340 birthing parents, of those who reported UITs of intentional infant-related harm (44.4%), 4 participants (2.6%; 95% CI, 0.9%–5.8%) disclosed engaging in physical aggression toward their infant, and, of those who did not endorse these thoughts (55.6%), 6 participants (3.1%; 95% CI, 1.3%–6.2%) engaged in

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Clinical Points

- Nearly 10% of new birthing parents experience unwanted and intrusive thoughts (UITs) of sexual harm related to their baby.
- Similarly to UITs of physical aggression toward the infant, which are not associated with an increased risk of physical harm, thoughts of sexual harm, when they are unwanted and intrusive, are not associated with touching one's baby in a sexual way.

this behavior.[4] However, this literature is limited to assessments of the association between UITs of physical harm and actual physical harm. There are no published reports of the relationship between UITs of infant-related sexual harm and actual sexual abuse of infants.

We identified 5 published reports of the prevalence of UITs of sexual harm among new birthing parents (eg, "What if I touch my baby's genitals in an inappropriate way?").[1,5–8] Estimates range from 3.8% to 11.6% (ie, 3.8%, 4.8%, 8.2%, 8.8%, and 11.6%).[1,5–8] Among those with estimates above 8.0%, participants were provided with perinatal-specific thought lists and normalizing information about infant-related UITs.[1,6,7] In the 2 studies reporting prevalence estimates below 5.0%, this was not provided.[5,8] This suggests that the true prevalence of postpartum UITs of infant-related sexual harm is most likely 8.0% or greater.

Research indicates that 25%–35% of child sexual abuse (CSA) cases involve children under the age of 7 years.[9,10] Despite significant prevalence among younger children, studies specifically examining CSA in infants remain extremely limited, due in large part to difficulty detecting these experiences among infants and ethical and legal barriers to conducting research of this nature.[11] This research gap is underscored by meta-analyses of global CSA prevalence studies, which find that none of the included studies reported on CSA in populations younger than 13 years old, making it impossible to determine prevalence rates for infants.[12]

Among experts in UITs and OCD, it is well known that neither UITs nor obsessions (ie, in OCD) are associated with any increased risk of violence. However, many scholars and health care providers lack this knowledge and fear that UITs of infant-related harm may lead to infant abuse. This lack of knowledge increases the risk of unnecessary monitoring for child abuse and erroneous reports to child protection agencies,[13] measures that can increase the risk of OCD.[14] This is particularly concerning given that nondangerous UITs represent the majority of infant-harming thoughts. Thoughts of sexual harm are often particularly distressing to parents and alarming to providers. Therefore, a better understanding of the specific association between sexual UITs and harm is needed. To our knowledge, the current report of findings represents the first published assessment of the association (if any) between UITs of infant-related sexual harm and sexual behavior toward the infant.

The objectives of the current study were to assess the following:

1. The period prevalence of UITs of infant-related sexual harm;
2. The association (if any) between the occurrence of UITs of infant-related sexual harm and
   a. Actual sexual behavior toward one's infant, and
   b. The number of weeks to follow-up available for each participant, and
3. Differences in obsessive-compulsive symptom severity between birthing parents who report UITs of infant-related sexual harm and those who did not.

METHODS

Study Design

This report of findings is based on a large, prospective, cohort study (N = 763). Only the methods relevant to this portion of the research are included here. The complete study protocol can be found in *BMC Psychiatry*.[15]

Ethics

The study was reviewed and approved by the University of British Columbia Behavioural Research Ethics Board, the Vancouver Island Health Authority, Vancouver Coastal Health Authority, and the Fraser Health Authority. Consent was obtained from participants twice: first during pregnancy (at 33 weeks gestation) for the prenatal assessment (ie, in pregnancy) and again at 7 weeks postpartum for the subsequent postpartum (ie, following the baby's birth) assessments.

To maximize honest disclosure, data related to infant-harming behaviors were collected anonymously, and multiple steps were taken to reassure participants.[15] A letter indicating approval for this aspect of our study methodology (ie, the fact that infant abuse data were collected anonymously and were therefore unable to report these behaviors to child protective services) was provided by the Ministry of Children and Family Development in British Columbia (BC), Canada. Although this approach to data collection prevented us from reporting suspected abuse to child protective services (as is required in Canada), it was deemed necessary in order to obtain valid data (ie, had this data collection not been anonymous, participants would not have disclosed these behaviors to us, and, consequently, we would not have been able to conduct valid assessments of abuse). See the study protocol for a detailed discussion of these issues.[15] Given the absence of literature on the prevalence of infant-related sexual

abuse, a priori sample size calculations were not conducted.

Inclusion Criteria

Pregnant people, 19 years of age or older, residing in BC, and fluent in English, were eligible to participate. For this report of findings, only participants who provided complete data on UITs of infant-related harm up to either the early or the late postpartum assessment were included.

Recruitment

Participants were recruited using hospital, community, and rurally focused approaches. We sought to maximize sample representativeness by recruiting proportionally across the 9 hospitals in BC with >1,500 deliveries annually.

Participants

Data were collected from February 9, 2014, to February 14, 2017. Demographic and reproductive information is reported in Table 1. A total of 1,115 perinatal (pregnant and postpartum) people expressed interest in the study. Of those, a total of 763 contributed data, with 502 providing data for this report of findings. Of the 763, a total of 636 enrolled and provided data prior to giving birth (n = 111 dropped out after the early postpartum assessment). One hundred thirteen (n = 113) entered the study in the early postpartum (many because they gave birth before they were able to complete the prenatal questionnaires or interview). Of these 113 people, 82 provided both early and late postpartum data. Finally, 13 people provided late postpartum data only. Those who dropped out did so because they (*a*) could not be reached, (*b*) were busy or working and no longer able to contribute to the study due to time limitations, or (*c*) experienced a high-risk pregnancy or had concerns regarding their infant's health and no longer had the time or resources to participate. It is common to lose participants between the end of pregnancy and the early postpartum. The demands of early parenting are intense and can make participation in research too difficult.

Procedures

Pregnant people who met the study eligibility requirements were invited to participate. Consenting participants completed online questionnaires and interviews in late pregnancy and twice postpartum. Among those who provided data for this report of findings (N = 502), these assessments occurred on average in pregnancy at 36.8 weeks' gestation (SD = 1.9, range = 33.0–41.0) and at 9.1 (SD = 1.9; range = 5.0–15.0) and 21.3 (SD = 3.8; range = 11.0–38.0) weeks postpartum.

Assessment Tools

Demographic, reproductive history, pregnancy, and birth-related information. This information (eg, age, marital status, pregnancy complications) was collected via self-report forms developed by our team and used extensively in our work.[4,15]

Parenting Behaviours Questionnaire. The Parenting Behaviours Questionnaire (PBQ)[15] is a 24-item anonymized self-report measure developed by our team to assess verbal (eg, "You screamed at your baby"), physical (eg, "You hit your baby"; "You shook your baby"), and sexual ("You touched your baby in a sexual way") aggression toward one's infant. The PBQ includes abuse items and filler items (positive parenting behaviors) appropriate for infants (eg, "You put your baby in his/her bouncy chair"; "You took your baby for a drive in the car"). There were a total of 12 aggression items and 12 filler items. Using a scale ranging from "never" to "10+ times," participants are asked to report how often, if at all, they had engaged in each behavior since their baby's birth. For the purposes of this analysis, only the sexual harm item ("You touched your baby in a sexual way") was used.

Postpartum Intrusions Interview. The Postpartum Intrusions Interview (PPII)[1] is a semistructured interview designed to assess UITs of accidental and intentional infant-related harm (ie, thought content, responses to the thoughts, and thought history). The PPII is divided into 2 sections. The first section asked about UITs of accidental infant-related harm and the second about UITs of intentional infant-related harm. The first section includes a list of 25 possible UITs of accidental infant-related harm, followed by 22 possible behavioral responses to these thoughts. The second section includes 20 possible UITs of intentional infant-related harm, followed by the same 22 possible behavioral responses listed in section 1. For each set of thoughts and behaviors, participants are asked about any others, not on the list, that they may have experienced. Participants indicate the frequency of each thought or behavior using the following scale: "never," "rarely," "sometimes," and "often." At the time of the first postpartum interview, participants were asked about thoughts they had experienced since their baby's birth. At the time of the second postpartum interview, they were asked about thoughts they had experienced since their last interview or, if they had missed the first postpartum interview, since their baby's birth. To encourage honest disclosure, the PPII begins by providing participants with normalizing information about postpartum UITs, including personal examples of UITs experienced by the interviewer. The PPII also includes questions about the history of their UITs of accidental and intentional harm and their infant's health. PPII interviews were conducted by trained research staff with backgrounds in psychology, most of whom were graduate students in clinical or counseling psychology. They were supervised by the

Table 1.

Demographic Information, Reproductive History, and Current Perinatal Period (N = 502)[a]

	n	%
Demographic characteristics		
Currently partnered	463	95.1
Education		
Did not complete high school	8	1.7
High school	33	6.8
Undergraduate or college	248	51.2
Master's or PhD	195	40.3
Cultural heritage		
European	278	57.4
Asian	114	23.6
Indigenous	11	2.3
Latin, Central, or South American	10	2.0
Mixed heritage	44	9.1
Not listed	27	5.6
Age, y	Mean (SD) = 32.7 (4.7)	Range = 18.0–46.8
Reproductive history		
Primiparous	281	58.3
Prior history of miscarriage	120	24.9
Current pregnancy, birth, and postpartum		
Mode of delivery		
Vaginal delivery	295	61.6
Cesarean delivery	184	38.4
Pregnancy complications	172	35.9
Labor/delivery complications	165	34.5
Episiotomy performed	45	9.4
Parent readmission to the hospital	38	7.9
Baby admitted to intensive or special care unit	61	12.2

[a]Percentages reported are for participants who provided data for each of the categories listed in Table 1 (ie, excludes those with missing data). A total of n = 15–18 participants were missing some demographic data, and n = 23–24 participants were missing some reproductive history and current perinatal period data.

principal investigator who provided extensive training in administering the PPII.

The PPII includes 3 UITs related to sexual harm: "touching your baby's genitals in an inappropriate way," "being 'turned on' sexually by your baby," and "touching your baby in a sexual way." For the purposes of this report of findings, PPII responses were used to categorize participants into those who reported UITs of infant physical aggression and infant-related sexual harm (PHYS + SEX) and those who reported UITs of infant physical aggression only (PHYS ONLY). The number of participants who reported UITs of sexual harm only was insufficient for a SEX ONLY group. For complete details about the PPII, please see our study protocol.[15]

Yale-Brown Obsessive Compulsive Scale. The Yale-Brown Obsessive Compulsive Scale (Y-BOCS) is an interviewer-rated, 10-item scale assessing obsessions (5 items) and compulsions (5 items) on a 0 (no symptoms) to 4 (extreme symptoms) scale, for a total possible score of 0–40.[16] The 5-item obsessions and compulsions scales are composed of questions related to (*a*) how time-consuming, (*b*) distressing, and (*c*) interfering their obsessions and compulsions are, as well as (*d*) how much control they have over them and (*e*) how able they are to resist them (ie, push the thoughts away for obsessions and resist engaging in the behaviors for compulsions). Overall, the Y-BOCS demonstrates adequate to excellent psychometric properties.[16,17] The maximum scores (as determined by the highest "most intense" score at either postpartum time point) for symptom time, distress, and impairment were included in the current analyses.

In this study, Y-BOCS items were minimally modified to assess infant-related obsessions and compulsions only. Terminology was adapted to reflect the clinical context; for example, "obsessive thoughts" was changed to "thoughts of harm related to your baby (accidental or intentional)." Items were also altered for clarity and relevance. For instance, item 6 was updated from "How much time do you spend performing compulsive behaviors?" to "How much time do you spend doing the things we just talked about (eg, checking, avoidance, reassurance seeking) in response to thoughts of harm related to your baby (accidental/intentional)?" Comparable adjustments were made throughout.

Participants were administered the Y-BOCS questions twice, once for UITs of accidental infant-related harm and

again for UITs of intentional infant-related harm. For each administration, participants were asked to answer Y-BOCS questions with respect to the previous week and most intense week. For the first postpartum interview, they were asked about the most intense week since the baby's birth. At the second postpartum interview, they were asked about the most intense week since the previous interview. In the current analysis of findings, we focus exclusively on Y-BOCS obsession items related to time, distress, and interference. Further, in this dataset, Cronbach alpha reliability for the time, distress, and impairment items ranged from .72 to .78 for both UITs of accidental and intentional infant-related harm, with one exception. Cronbach alpha was .59 for the most intense period from birth to the first postpartum interview for UITs of intentional harm.

Data Analysis

Data were analyzed using IBM SPSS Statistics (Version 28).[18] Descriptive statistics were reported, and 95% binomial confidence intervals (CIs) for prevalence rates were generated using the Clopper-Pearson exact method. Fisher exact test was employed to test the association between UITs of infant-related sexual harm and sexual harming behaviors. Prevalence estimates for UITs of infant-related sexual harm are provided for period prevalence (ie, from the infant's birth to the time of the first postpartum interview and from the infant's birth to the time of the second postpartum interview).

Participants were invited to participate in 2 postpartum interviews. Not all participants completed all of the postpartum interviews. Further, because of challenges related to reaching new parents and scheduling times with them, some overlap between the number of weeks postpartum when the first and second postpartum interviews occurred (eg, some participants' second postpartum interview may have been administered later than another participant's first postpartum interview). To address these issues, we did the following. First, we report on data only from participants who provided complete data from their infants' birth up to either the first or second postpartum interview. As there is also the possibility that participants' endorsement of UITs infant-related sexual harm was attributable to the number of weeks into their postpartum they were assessed (ie, the later into their postpartum that they were assessed, the more likely they were to have endorsed a UIT of infant-related sexual harm at some point in the postpartum), limiting the accuracy of the prevalence of these UITs that we report, Mann-Whitney *U* tests and logistic regressions were employed to test for any association between the presence of UITs of infant-related sexual harm and the number of postpartum weeks of follow-up. Mann-Whitney *U* tests were used to compare Y-BOCS time, distress, and interference scores (based on the maximum score of the 2 "most intense" weeks assessed) between participants who (*a*) reported UITs of infant physical aggression and infant-related sexual harm (PHYS + SEX) and (*b*) reported UITs of infant physical aggression only (PHYS ONLY). The number of participants who reported UITs of sexual harm but not physical aggression was insufficient for a SEX ONLY group.

RESULTS

Prevalence of UITs of Infant-Related Sexual Harm

Six percent (6.1%; n = 25; 95% CI, 4.0–8.8) of study participants who provided complete data for UITs of infant-related sexual harm from the time of their baby's birth to the time of the first postpartum interview (n = 412) reported 1 or more UITs of infant-related sexual harm. Nine percent (9.2%; n = 38; 95% CI, 6.6–12.4) of participants who provided complete data for UITs of infant-related sexual harm from the time of their baby's birth to the time of the second postpartum interview (n = 414) reported 1 or more UITs of infant-related sexual harm. Of the 324 participants who completed both the early and the late postpartum PPII and provided complete data for both time points, 4.8% (n = 16; 95% CI, 2.8–7.7) reported UITs of infant-related sexual harm at the early postpartum assessment only, 2.5% (n = 8; 95% CI, 1.1–4.8) at the late postpartum assessment only, and 2.2% (n = 7; 95% CI, 0.9–4.4) at both.

The period prevalences of specific UITs reported at any time from birth to the time of the second postpartum interview were as follows: "touching your baby's genitals in an inappropriate way," 8.5% (n = 35; 95% CI, 6.0–11.6); "being 'turned on' sexually by your baby," 2.9% (n = 12; 95% CI, 1.5–5.0); and "touching your baby in a sexual way"; 1.7% (n = 7; 95% CI, 0.7–3.5).

No association between participants' self-report of UITs of infant-related sexual harm and number of weeks postpartum was found, either (a) when comparing participants who did (mean = 21.21 weeks, *SD* = 3.88) and did not (mean = 21.31 weeks, *SD* = 3.81) report these thoughts ($z = -.301$, $P = .763$), or (b) when using weeks postpartum as a predictor of UITs of infant-related sexual harm via logistic regression ($\chi^2_1 = 0.03$, $P = .873$).

Association With Infant Sexual Harm

Among the 502 participants, a total of 330 participants provided data related to their UITs up to and including the second time point and data related to infant-harming behaviors (ie, completed the PBQ). Of these, only 1 participant reported touching their infant sexually (on 10+ occasions). No UITs of infant-related sexual harm were reported by this participant. Consequently, Fisher exact tests revealed no association between UITs of infant

sexual harm and actual sexual behavior toward the infant ($P = 1.00$, 95% CI, −.0003 to .009).

Obsessive-Compulsive Symptom Severity

Table 2 reports median maximum postpartum (any time point) Y-BOCS time, distress, and impairment scores associated with UITs of infant-related intentional harm, stratified by thought type (ie, physical harm only, n = 138, and both physical and sexual harm, n = 33). Participants who reported UITs of both physical and sexual harm reported experiencing these thoughts as more time-consuming ($z = -3.46$, $P < .001$) but not more distressing or impairing ($P = .083$ and .956, respectively) compared with those who reported UITs of physical harm only.

DISCUSSION

The period prevalence estimate for UITs of infant-related sexual harm from birth to, on average, 5 months postpartum obtained in this study (ie, 9.2%) is consistent with previous estimates obtained in studies of new birthing parents where participants were provided with perinatal-specific thought lists and normalizing information about infant-related UITs (as was the case in our study).[1,5,6] In the 2 studies reporting prevalence estimates below 5.0%, perinatal-specific thought lists and normalizing information were not provided.[4,7] As discussed in the introduction, the extant data suggest that providing perinatal-specific thought lists and normalizing information likely enhances disclosure. Consequently, our findings add to the extant research suggesting that the prevalence of postpartum UITs of sexual harm likely falls between 8.0% and 12.0%.

In the 2 published studies assessing the relationship of UITs of infant-related harm with actual harming behaviors (N = 100 and N = 388),[1,4] no evidence of a relationship with actual harm was found. However, both investigated the relationship between UITs of infant-related physical harm and actual physical aggression toward the infant. This report of findings represents (to our knowledge) the first assessment of the relationship of UITs of infant-related sexual harm with sexually harming behaviors. Consistent with our hypothesis, the occurrence of UITs of infant-related sexual harm was not associated with sexually harming one's infant. Although the precision of our estimate (ie, 95% CI, −.0003 to .009) cannot rule out this possibility, our findings add to accumulating evidence indicating that UITs of infant-related harm are not associated with an increased risk to infant safety and provide additional reassurance that this is true of UITs of infant-related sexual harm also.

Although more time-consuming, the presence of UITs of infant-related sexual harm was not associated with higher levels of distress or impairment in this sample. It is not surprising that people who report UITs of both physical and sexual harm experience them as more time-consuming than people who report UITs of physical, infant-related harm only. Experiencing UITs across a broader range of content areas would likely render them more time-consuming.

Strengths

To our knowledge, this is the first published report of an assessment of the relationship of UITs of infant-related sexual harm with sexual harming behaviors toward one's infant. Our findings also provide additional evidence regarding the prevalence of UITs of infant-related sexual harm among birthing parents of infants.

An important methodological aspect of this study is that data related to child harming behaviors were collected anonymously. This is a challenging aspect of any study of child abuse. In order to learn about the prevalence of these events, parents must be willing to disclose these behaviors. When data are collected openly (ie, without anonymity), parents are highly unlikely to engage in honest disclosure. In our opinion, collecting abuse data in such a way that the abuse can be reported would (*a*) result in incomplete and unreliable data and (*b*), given the low probability of disclosure, also fail to result in the discovery or prevention of any current or ongoing abuse. As such, we deem our approach to be the most ethical (ie, it is better for the health and safety of children to learn about the nature and prevalence of abuse than to collect data that are noninformative and unlikely to result in learning about current, ongoing abuse). Many international studies of infant abuse have also taken this approach, and our team has now given a talk at an ethics conference about our approach.[19–22]

Limitations and Future Directions

As is true of all studies of child abuse, underreporting of UITs of harm and infant-harming behaviors is possible, particularly given the use of self-report for sensitive disclosures such as infant sexual harm. However, our use of multiple strategies designed to maximize disclosure likely limited this.

While numerous efforts were made to recruit a representative sample of birthing people in BC (eg, proportional recruitment across hospitals in BC), quite a few participants provided incomplete data or dropped out partway through the study. In addition, the study sample was fairly wealthy and well educated. Although it is common for wealthier and more educated people to participate in research, and loss to follow-up is common among participants who are parents of newborns, both nevertheless impact generalizability. For example, external stressors such as financial instability and low social support may impact the occurrence of UITs of infant-related harm and infant-harming behaviors.[1] Our

Table 2.
Y-BOCS Time, Distress, and Impairment by UIT Type (n = 171)[a]

	Physical harm only (n = 138)		Physical and sexual harm (n = 33)			
	Median (IQR)	Mean rank	Median (IQR)	Mean rank	*z*	*P*
Time	1.1 (0.2)	80.14	1.3 (0.4)	110.52	−3.46	**<.001*****
Distress	2.0 (1.0)	82.98	2.0 (1.0)	98.62	−1.73	.083
Impairment	0.0 (1.0)	86.09	0.0 (1.0)	85.64	−0.055	.956

[a]Reported scores and group comparisons are based on maximum Y-BOCS obsession scores in the postpartum associated with UITs of intentional infant-related harm, with possible scores for each dimension ranging from 0 to 4.
****P* < .001 level of significance.
Abbreviations: IQR = interquartile range, UIT = unwanted intrusive thoughts, Y-BOCS = Yale-Brown Obsessive Compulsive Scale.

sample is also limited to birthing parents. Future work should include nonbirthing parents and increase sample diversity to be representative of demographic characteristics, like income and education, of the BC population.

The timing of the study's postpartum assessments varied significantly. Although we found no relationship between the likelihood of reporting UITs of infant-related sexual harm and the follow-up period of assessments, future research will, ideally, provide more detailed estimates of the point and period prevalence of UITs of infant-related sexual harm by week or month postpartum.

Although we failed to find a relationship between reports of UITs of infant-related sexual harm and actual sexual behavior toward one's infant, sample sizes were too small to rule out this possibility. Replication of our findings in a larger sample is needed to confirm this relationship, although given the paucity of information on the prevalence of infant sexual harm, the sample size needed to adequately detect this behavior (especially when studying the behavior of parents vs other infant caregivers) remains unknown. Large-scale studies on sexual abuse among infants are needed to inform future studies on this topic.

CONCLUSION AND CLINICAL IMPLICATIONS

Study findings support existing estimates of the prevalence of UITs of infant-related sexual harm and add to evidence indicating that UITs of infant-related harm do not represent a risk to infant safety. Even once the principle is understood that UITs are a common experience, this form of UIT can be difficult for parents to disclose, due to fears that they may comprise a distinct category of experience, concerns which can be mirrored by health care professionals. The knowledge that they are not in fact unique and dangerous is important for postpartum individuals, their families, perinatal/maternity care providers, child protection workers, and policymakers. However, larger, more diverse samples are required to be sure of this conclusion.

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