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Research article

Parent–Child Interaction Therapy for sexual concerns of maltreated children: A preliminary investigation

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ABSTRACT

The current study examines whether an evidence-based treatment for externalizing behavior problems may reduce sexual concerns among children with maltreatment histories. An archival analysis identified 44 children between the ages of 3 and 8 exhibiting externalizing problems and co-morbid sexual concerns who were treated using Parent–Child Interaction Therapy (PCIT). A second group of children receiving PCIT for externalizing behaviors without sexual concerns was included for comparison purposes ($n = 143$). Wilcoxon Signed-Ranks Tests indicated significant improvement among the group with sexual concerns, with 63.6% of children no longer displaying clinically significant sexual concerns at post-treatment. In addition, these children showed a decline in general externalizing problems comparable to that observed among the group of children receiving PCIT and not displaying sexual concerns. Lastly, logistic regression analyses showed that pre-treatment posttraumatic stress scores did not moderate improvement of sexual concerns, suggesting that posttraumatic stress-related sexual concerns may improve from PCIT treatment. These findings suggest that evidence-based parent training interventions, specifically PCIT, may successfully reduce sexual concerns among children who experienced maltreatment.

Research suggests that children experiencing sexual abuse are at increased risk for displaying various sexual concerns, including problematic sexual behavior (e.g., removing the clothes of others, simulating sexual acts), sexual preoccupation, and sexual anxiety (Friedrich et al., 2001; Kendall-Tackett, Williams, & Finkelhor, 1993). Indeed, some of the most prominent etiological theories of sexual concerns among children emphasize the social learning of sexual behavior and posttraumatic stress symptoms that commonly occur as a result of sexual abuse (Finkelhor & Browne, 1985). Supporting this contention, Allen, Thorn and Gully (2015) found that sexually abused children with sexual behavior problems were more likely to report posttraumatic stress symptoms than sexually abused children without sexual behavior concerns. However, findings note that other forms of child maltreatment (e.g., physical abuse, neglect) also increase the risk for sexual concerns (Merrick, Litrownik, Everson, & Cox, 2008) and it is generally regarded that a large proportion of children displaying sexual concerns, likely greater than 50%, do not have a sexual abuse history (Allen, in press; Bonner, Walker, & Berliner, 1999; Silovsky & Niec, 2002).

Another etiological hypothesis is that sexual concerns among children may be the result of core emotion and behavior regulation deficits (Chaffin, Letourneau, & Silovsky, 2002). In this model, sexual concerns are typically conceptualized as

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occurring within the context of other comorbid conditions. Support for this developmental psychopathology perspective is drawn from findings suggesting that children with sexual concerns are more likely to display externalizing problems (Lévesque, Bigras, & Pauzé, 2012; Allen et al., 2015), poor emotion regulation (Lepage, Tourigny, Pauzé, McDuff, & Cyr, 2010), and social skills deficits (Friedrich, Davies, Feher, & Wright, 2003).

From a treatment perspective, Trauma-Focused Cognitive-Behavioral Therapy is a well-established treatment for children experiencing various forms of trauma, and research suggests it is effective for treating sexual concerns associated with posttraumatic stress among children with sexual abuse histories (Cohen, Deblinger, Mannarino, & Steer, 2004; Deblinger, Staufer, & Steer, 2001). However, many clinicians are uncertain how to proceed in treatment if the presenting sexual concerns are not related to sexual abuse and/or the child does not display posttraumatic stress symptoms, as a trauma-focused intervention specifically targeting sexual abuse-related sequelae is not indicated. A meta-analysis by St. Amand, Bard and Silovsky (2008) identified only four studies targeting sexual concerns that used interventions other than trauma-focused cognitive-behavioral models focused on ameliorating posttraumatic stress (Bonner et al., 1999; Gagnon, Tremblay, & Begin, 2005; Pithers, Gray, Busconi, & Houchens, 1998; Silovsky, Niec, Bard, & Hecht, 2007). Each of these four studies examined group administered protocols, which may not be feasible in many practice settings. In addition, externalizing behavior problems were not the primary focus of these groups and it is unclear if these group treatment protocols would be the appropriate choice for a child with broader externalizing problems.

Some have recommended that sexual concerns occurring within the context of broader externalizing problems be treated with behavioral parent-training models validated for treating externalizing problems (Chaffin et al., 2006). Supporting this recommendation is data from the St. Amand et al. (2008) meta-analysis, which found that the techniques most effective in reducing problematic sexual behavior are primarily parent-focused and include the use of behavioral child management skills, building the parent–child relationship and improving communication, and setting appropriate limits on behavior. It should be emphasized that, although evidence-based parent-training interventions are recommended for sexual concerns among children, no studies of evidence-based parent-training interventions for child sexual concerns were found by St. Amand et al., and no such studies have been published since their meta-analysis.

Parent–Child Interaction Therapy (PCIT; McNeil & Hembree-Kigin, 2010) is a parent-training program with considerable empirical support for the treatment of childhood externalizing behavior problems (Eyberg, Nelson, & Boggs, 2008; Thomas & Zimmer-Gembeck, 2007). PCIT results in improved parent–child relationships and reduced externalizing problems by teaching caregivers how to provide positive attention to children for desired behaviors and deliver appropriate consequences for undesired behaviors. In the first portion of PCIT, Child-Directed Interaction (CDI), caregivers are taught to use techniques such as praising appropriate behaviors, reflecting a child's verbalizations, and describing the child's behavior. In the second phase of PCIT, Parent-Directed Interaction (PDI), caregivers are taught to establish rules, deliver effective commands and provide non-violent forms of discipline for non-compliance and rule-breaking. A hallmark feature of PCIT is that the clinician provides in vivo coaching to the parent in the use of the skills while the parent interacts with his or her child during session. For more information on PCIT, the reader is referred to McNeil and Hembree-Kigin (2010) and Borrego, Klinkebiel and Gibson (2014). Importantly, PCIT incorporates many of the parent-focused components St. Amand et al. (2008) linked to positive outcomes for problematic sexual behavior, such as the use of behavior management techniques, improving communication in parent–child relationship, and setting appropriate limits on behavior. In addition, clinical observations suggest that PCIT may be effective with children exhibiting sexual concerns (Friedrich, 2007).

The current study examines the effectiveness of PCIT with children displaying sexual concerns, broadly conceived to include problematic sexual behavior, sexual anxiety, and sexual preoccupation, as well as co-morbid externalizing problems. Based on previous research and theory, we developed the following hypotheses:

1. PCIT would result in significant reductions of sexual concerns.
2. PCIT would result in significant reductions of externalizing problems, in general.
3. The improvement of sexual concerns as a result of PCIT would be moderated by pre-treatment posttraumatic stress scores. Given that PCIT and other behavioral parent-training programs do not focus specifically on ameliorating symptoms of posttraumatic stress (e.g., intrusive thoughts), posttraumatic stress-related sexual concerns may not respond to PCIT in the same manner as sexual concerns not resulting from posttraumatic stress. As such, we expected that children with higher pre-treatment posttraumatic stress scores would show smaller changes in sexual concerns than children with less posttraumatic stress.

Method

Participants

Archival data were obtained from a sample of 187 caregiver–child dyads referred to PCIT between January 2004 and January 2014 for treatment of children's externalizing behavior problems. Dyads were eligible for inclusion if the caregiver completed the Trauma Symptom Checklist for Young Children (TSCYC) pre- and post-treatment, and the child was at least 3 and less than 8 years of age. If more than one caregiver was in treatment with the child, the caregiver participating in PCIT was selected. If more than one child in a family was in treatment, we made a decision to select one child according to the following criteria, and in this order: (1) the child who completed more PCIT sessions; (2) the child