



Parent-Child Interaction Therapy and young children with Problematic Sexual Behavior: A conceptual overview and treatment considerations

Paul M. Shawler*, M. Elizabeth Bard, Erin K. Taylor, Carisa Wilsie, Beverly Funderburk, Jane F. Silovsky

University of Oklahoma Health Sciences Center, United States

A B S T R A C T

Problematic Sexual Behavior (PSB) can be conceptualized as a distinct subset of externalizing behavior problems. Preschool children with PSB commonly have co-occurring nonsexual behavior problems, including disruptive behavior disorders (DBD). Behavioral parent training is the core component of effective treatments for DBD (Kaminski, Valle, Filene, & Boyle, 2008) and for PSB (St. Amand, Bard, & Silovsky, 2008). Parent-Child Interaction Therapy (PCIT) is an empirically supported evidence-based behavioral parent treatment program for young children ages 2 to 7 with disruptive behavior problems (California Evidence-Based Clearinghouse, 2017; Eyberg & Funderburk, 2011; Funderburk & Eyberg, 2011). However, due to the taboo nature of the topic and the potential impact and harm to other children, unique clinical issues can arise when behaviors are classified as “sexual.” Adaptations to PCIT are recommended to address safety, physical boundaries, commonly held myths about the population, and other related issues. Conceptual background of PSB and the fit of behavioral parent training as a core intervention is provided, followed by details regarding augmentations to embed approaches to address PSB within PCIT.

1. Introduction

Problematic Sexual Behavior (PSB) of children is characterized as developmentally inappropriate or potentially harmful behavior that involves the use of sexual body parts (Chaffin et al., 2008). Types of PSB fall on a continuum from poor boundaries to engaging in interpersonal PSB, which could include attempted sexual intercourse, insertion of objects, and oral-genital contact (Friedrich & Luecke, 1988; Johnson, 1988; Silovsky & Niec, 2002). PSB in young children (ages 3–6) is more prevalent in females, and the behavior is characterized as more impulsive and frequent than in older children (Silovsky & Niec, 2002). For many of these young children, their PSB is part of a pattern of disruptive behavior problems, including breaking rules at home and day-care, oppositional responses, and impulsive acts (Chaffin et al., 2008).

It is important to highlight that children with PSB differ substantially from adolescents and adults with sexual behavior concerns (Chaffin et al., 2008; Chaffin & Bonner, 1998; Chaffin, Letourneau, & Silovsky, 2002). Although sexual body parts are involved in the behavior, for young children the motivations, intentions, culpability, context, and responsivity to caregiver, community, and clinical

interventions are quite distinct from adolescents and adults (Bonner, Silovsky, Widdifield Jr., Shawler, & Bard, 2017; Chaffin et al., 2002). Friedrich (2007) reported that sexual behavior exhibited by young children does not focus on sexual arousal, “but a combination of exploration, happenstance, impulsivity, and curiosity (p. 42).” Furthermore, the early emergence of PSB does not appear to lead to a trajectory of sexual offending behavior into adolescence and adulthood (Carpentier, Silovsky, & Chaffin, 2006; Chaffin et al., 2002).

The development and maintenance of PSB involves a complex and multifaceted matrix of potential contributing factors including: exposure to nudity, sexual acts or materials, parenting practices, child maltreatment and other trauma histories (e.g., family violence, sexual and physical abuse, neglect), and individual child factors like co-occurring disruptive behavior problems, developmental factors, and coping skills (Chaffin et al., 2008; Friedrich, Davis, Feher, & Wright, 2003; Gray, Pithers, Busconi, & Houchens, 1999). PSB is not a distinct psychiatric diagnosis (see American Psychiatric Association, 2013) but rather best conceptualized in terms of the co-occurring symptoms, antecedents, and protective factors at the individual, family, and community level (Elkovitch, Latzman, Hansen, & Flood, 2009). The

* Corresponding author at: University of Oklahoma Health Sciences Center, Center on Child Abuse and Neglect, 940 NE 13th Street, Nicholson Tower, Suite 4900, Oklahoma City, OK 73104, United States.

E-mail addresses: paul-shawler@ouhsc.edu (P.M. Shawler), elizabeth-bard@ouhsc.edu (M. Elizabeth Bard), erin-taylor@ouhsc.edu (E.K. Taylor), carisa-wilsie@ouhsc.edu (C. Wilsie), beverly-funderburk@ouhsc.edu (B. Funderburk), jane-silovsky@ouhsc.edu (J.F. Silovsky).

<https://doi.org/10.1016/j.childyouth.2017.12.006>

Received 7 August 2017; Received in revised form 5 December 2017; Accepted 5 December 2017

Available online 06 December 2017

0190-7409/ © 2017 Elsevier Ltd. All rights reserved.

expression of PSB in young children (ages 3–6) is often compounded by adjustment and developmental challenges, including poor emotion regulation and social skill deficits (Friedrich et al., 2003; Lepage, Tourigny, Pauzé, McDuff, & Cyr, 2010) as well as co-occurring externalizing and internalizing behavior problems (Allen, Thorn, & Gully, 2015; Lévesque, Bigras, & Pauzé, 2012; Silovsky & Niec, 2002; Silovsky, Niec, Bard, & Hecht, 2007). As a result, the level of interference in functioning is broad, as preschool children with PSB have difficulty staying in daycare, problems entering or staying in school, and frequent placement disruptions (Baker, Schneiderman, & Parker, 2001; N'Zi, Hunter, & Silovsky, 2017). Thus, it is prudent that intervention efforts for young children with PSB account for their development, the context, and the pattern of co-occurring emotional and behavioral concerns.

This article reviews effective treatment of PSB with preschoolers, examines the core components of an existing and widely disseminated effective behavioral parent training (BPT) protocol (i.e., Parent-Child Interaction Therapy: PCIT), and provides a conceptual model for treating young children with PSB and co-occurring disruptive behavior disorders (DBD) through an adaptation of PCIT augmented with unique treatment components for PSB. PCIT was selected due to the program's demonstrated effectiveness and utility for a range of early childhood problems. PCIT has repeatedly received the highest rankings among reviews of evidence-based treatments (e.g., California Evidence-Based Clearinghouse for Child Welfare, 2015) and has been proposed for use with children with PSB by experts in the field (Allen, Timmer, & Urquiza, 2016; Friedrich, 2007; Silovsky et al., 2007).

2. Treatment of preschoolers with Problematic Sexual Behavior

Preschool children with PSB are heterogeneous in terms of etiological influences and co-occurring clinical concerns. Previous research examining clusters of context and co-occurring factors found support for three subgroups: (a) *PSB exclusive focus* – children with access/exposure to sexualized material who demonstrate non-intrusive sexual behaviors at a higher frequency than typical; (b) *Disruptive behaviors* – children who exhibit a pattern of externalizing behaviors including intrusive PSB, and may have been exposed to harsh parenting or violent environment; and (c) *Complex* – children with multiple traumas and complex family/individual factors who present with high frequency and intrusive PSBs, as well as internalizing (e.g., Post-Traumatic Stress Disorder [PTSD], Depression) and externalizing symptoms (Silovsky, Campbell, & Bard, 2013). Notably, across 151 preschool aged children with PSB, 23%, 45%, and 32% of the children fell in categories a, b, and c, respectively (Silovsky et al., 2013). Treatment outcome research thus far provides support for interventions to address PSB in young children and provides pathways to bolster treatments for children when PSB is part of a pattern of disruptive behaviors and complex presentations.

For instance, when preschool children with PSB have a sexual abuse history and Posttraumatic Stress Disorder (PTSD), Trauma-Focused Cognitive Behavior Therapy (TF-CBT) has effectively reduced PSB at post-treatment and one-year follow-up (Cohen & Mannarino, 1996, 1997; Stauffer & Deblinger, 1996). When investigating the length and components of TF-CBT, the developers found that longer treatment with greater focus on BPT has been particularly effective for addressing PSB and other externalizing behaviors in children with sexual trauma (Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012). While it is beyond the scope of the current article, further considerations for implementing TF-CBT with children with PSB can be found in Allen (2017).

Many preschool aged children with PSB do not present with a known history of sexual abuse or PTSD. As such, a specific intervention that directly targeted PSB for young children was developed (Silovsky et al., 2007; Silovsky & Niec, 2002). Cognitive Behavioral Therapy for Preschoolers with Problematic Sexual Behavior and their Families (PSB-CBT-P) is a closed-ended, group therapy model consisting of 12 sessions that focus on providing a developmentally sensitive treatment model

designed for young children's cognitive, emotional, and behavioral capacities (Silovsky et al., 2007; Silovsky, Niec, Widdifield, Campbell, & Funderburk, 2015). The therapy model is rooted in behavioral and cognitive-behavioral principles. The child and caregiver(s) are actively involved. The caregiver component of treatment addresses psychoeducation on sexual development and PSB, parenting skills to supervise, monitor, prevent, and respond to PSB, general BPT skills, and embeds caregiver support through the group processes. The children's group is focused on learning healthy boundaries, rules about behavior, coping skills, self-control skills, and social skills. In a multi-subject ($N = 85$), multiple baseline (wait and treatment periods) study, significant reductions in PSB were found for treatment above and beyond the wait period (Silovsky et al., 2007).

Further, support for the importance of caregivers and BPT on treatment effects was found in the meta-analysis of PSB treatment outcome studies (St. Amand, Bard, & Silovsky, 2008). This meta-analysis specifically examined which components of the treatments were related to positive outcomes for PSB and BPT had the strongest relationship to reductions in PSB. Other components that significantly improved treatment effects included addressing rules about sexual behavior, sex education, and abuse prevention with the caregivers (St. Amand et al., 2008). The only component directly addressed with the children related to reductions in PSB was teaching self-control skills, furthering evidence supporting the conceptualization of PSB as a disruptive behavior problem.

Identifying an appropriate treatment approach can lead to clinician uncertainty when multiple treatment protocols are available that address individual presenting problems (Chorpita & Daleiden, 2014). Within other child mental health populations, researchers have created unified protocols and modular treatments to address a variety of complex client needs. For example, the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct problems (MATCH-ADTC; Chorpita & Weisz, 2009) includes treatment modules for the most common presenting problems in childhood. A modular approach may reduce clinician uncertainty by offering a map or flow-chart of how a treatment protocol may target multiple presenting problems. Modular approaches improve treatment delivery as well as enhance availability and access to care (Chorpita & Daleiden, 2009; Weisz, Ugueto, Cheron, & Herren, 2013). To date, treatment of PSB has not been included in the available modular treatment protocols. Modular approaches are particularly appealing when working with young children with PSB given the multiple subgroupings that exist.

While PCIT has been proposed as a treatment model for PSB (Allen et al., 2016; Friedrich, 2007; and Silovsky et al., 2007), no studies to date have tested PCIT for children with PSB. Allen et al. (2016) conducted a study with PCIT with children with sexual concerns. Sexual concerns may include some aspects of PSB or may be conceptualized as internalizing symptoms consistent with symptoms of posttraumatic stress. Allen et al. (2016) found that following treatment with PCIT, a sizable minority (36.4%) of children continued to demonstrate elevated sexual concerns and, children with sexual concerns at pretreatment were more likely to have elevated disruptive behavior problems at posttreatment. Therefore, it appears that the implementation of an unmodified BPT (i.e., PCIT) may be insufficient for a number of children with PSB.

Allen et al. (2016) identified clinician uncertainty for children who present for treatment with sexual concerns. For this unique population, a streamlined model that maximizes evidence-based treatment components and targets PSB in the context of other treatment goals would reduce clinician uncertainty about the treatment of PSB and improve access to effective services. In particular, this article focuses on young children who present with co-occurring PSB and clinically significant levels of disruptive behavior problems from both the *disruptive behaviors* and *complex* subgroupings (Silovsky et al., 2013). It is beyond the scope of the current article to formally propose and outline decision rules for treatment selection for children with PSB. However, children who

Download English Version:

<https://daneshyari.com/en/article/6833513>

Download Persian Version:

<https://daneshyari.com/article/6833513>

[Daneshyari.com](https://daneshyari.com)