CHAPTER FIVE

Consensus-Based Treatment Areas and Suggestions for Work with Primary Caregivers

Too often, professionals have adapted the principles that guide the treatment of adult sexual offenders to working with children and adolescents who have sexual behavior problems. However, there are enormous developmental differences between children with sexual behavior problems and adult sexual offenders; the therapy provided for each age group must reflect these differences (Friedrich, 2007). Unfortunately, persisting stereotypes continue to interfere with the delivery of developmentally appropriate treatment interventions for young and school-age children. The children are viewed as victims of sexual abuse or as future sex offenders. As we have noted in Chapter One, neither stereotype is accurate for the majority of children who exhibit sexual behavior problems. Nevertheless, because of perceptions shaped by these beliefs, children often face repercussions that do not treat their underlying issues or correspond to their actions (Friedrich, 2007). Friedrich has encouraged a revised and broader set of perspectives on children's sexual behavior problems, including a focus on attachment, ego development, self-regulation, and relational issues in therapy. Attachment dynamics and family relationships have traditionally been ignored, even when they are usually the largest contributors to these problems.

CONSENSUS-BASED AREAS FOR TREATMENT

The recent research on treatment of young and school-age children with sexual behavior problems has produced the following broad consensus-based areas for treatment: (1) therapeutic attention to trauma when appropriate (with a flexible approach to integrating a focus on the trauma with a focus on the sexual behavior problems); (2) active, direct caregiver involvement in treatment; and (3) inclusion of psychoeducation and CBT-focused interventions for direct management of sexual behavior problems. In addition, several key treatment factors have been shown to promote the long-term effectiveness of therapeutic interventions. These other factors include implementing family and community controls (clear limits, safety/supervision, and limit setting) to contain the sexual behaviors and reduce the potential for further exposure to sexualized material; teaching coping skills; assisting children directly with emotional regulation; facilitating relationship building between a child and his or her primary caregiver; and building supports outside of treatment.

Consensus-Based Area 1: Therapeutic Attention to Trauma When Appropriate

A developmentally sensitive assessment prior to treatment selection (see Chapter Four) is highly recommended in order to determine the priority and sequence of treatment foci for the referred child, caregiver(s), and/or other family members. When a child presents with both a serious sexual behavior problem and a significant trauma history, important clinical questions arise. As noted by Chaffin et al. (2006), if the child is exhibiting significant trauma-related symptoms, trauma-focused treatment may be the first priority or the primary focus in interventions. For a child without significant trauma symptoms or other internalizing symptoms (e.g., anxiety, depression), an approach focused on the sexual behavior problem itself may be a better fit—especially in a case where the trauma was not proximal to the onset of the problem (Chaffin et al., 2006; Silovsky et al., 2012).

Chaffin et al. (2006, p. 18) suggest the following approach to treatment consideration and selection in cases involving trauma or other comorbid problems:

> For example, when children with SBP [sexual behavior problems] primarily suffer from serious traumatic stress symptoms, trauma-focused

[approaches are] considered, with added SBP components addressing necessary environmental changes, supervision, and self-control strategies. When SBP are one element of a broad, overall pattern of early childhood disruptive behavior problems, well-supported models such as Parent–Child Interaction Therapy (Brestan & Eyberg, 1998), The Incredible Years (Webster-Stratton, 2006), Barkley's Defiant Child protocol (Barkley & Benton, 2013), or the Triple-P program (Sanders, Conn & Markie-Dadds, 2003) might be considered, integrated with SBP specific treatment components. When the primary problem is a chaotic or neglectful family environment, interventions focused on creating a safe, healthy, stable and predictable environment may be the top priority. When insecure attachment is a major concern, short-term interventions emphasizing parental sensitivity have been found to be the most effective (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003).

Clinical Illustration

Clinical presentations involving trauma can be varied and complex. I (J. A. S.) worked with a 10-year-old boy who started treatment 5 weeks after he was discovered in his bedroom playing a "penis game" with his 5-year-old male cousin. My client, Frankie, had asked the 5-year-old to suck his penis, and had bribed him with a video game. An assessment of my client and collateral data from an investigation on behalf of the victim determined that this was the second incident.

I first met with my client's uncle and grandparents (with whom he presently lived), and they made it clear that they expected me to find this child in need of residential treatment; they asked me for funding resources and referrals for treatment centers. The uncle admitted to being enraged. He told me that he had yelled at his nephew, grabbed him, spanked him with a belt, and then isolated him in his room until child protective services could respond to his call. Frankie had waited in his room for 7 hours, listening intently to his grandmother, grandfather, uncle, and young cousin yelling and then crying about what had occurred. He heard his uncle storm around the house for several hours, periodically recounting the incident to those who returned his call: the police, then a child protective services hotline worker, then a detective who was assigned to the case. By the time this child got to my office for an assessment (which seemed to have been arranged mainly because of the caregivers' desire for "proof" of a need for placement in a residential facility), no one had genuinely talked with him. His relatives had

given him only directives to stay far away from his cousin, and he had been interviewed by a detective whose interest was primarily in exploring the "offense" and how many times he had victimized the younger boy. His punishment to date had been isolation, and he had started to withdraw.

For 5 weeks, Frankie went to school and came home to his bedroom. He was taken off sports teams, and toys were stripped from his bedroom. He watched his young cousin receive special attention, such as going on extra outings with his uncle and grandparents. His caregivers were afraid and confused; they seemed to huddle in secrecy, to talk only with one another, and to avoid and ignore Frankie.

Frankie stopped talking to peers and teachers at school. He also started wetting the bed. Although he was even more afraid and confused than his caregivers were, these feelings were mistaken for "no empathy" at the next treatment team meeting, which took place 6 weeks after the incident. As the concerns of the various adults involved swirled during this time, and they turned to each other for support, Frankie was left to his own thoughts and perceptions that the adults only cared about protecting other children from him.

When I met with Frankie's uncle, I asked questions about my client's first 5 years of development. The still-enraged uncle replied, "Does it matter? We all have bad things happen to us, but we don't do *that*!" I responded, "In order for me to help, I need to know as much as I can about the good and bad stuff that happened to Frankie, because you're right—his actions likely are an expression of something bad that happened." The uncle proceeded to tell me about all the ways, since the child was 8 years old, that he had tried to be a parent figure to Frankie (e.g., "I took him to football practices and treated him like my own son"). I felt optimistic about his obvious investment in this child and recognized (out loud) that the uncle felt betrayed by Frankie. "All this is good to know," I told him. "He's going to need a father figure, and it sounds like you've already started building a strong relationship. Sounds like the 'bad things' might have happened before he came to live with you, before he was 8."

Frankie's grandmother then stepped in and provided as many details as she could. Like the uncle, she had had no contact with her grandson for the first 7 years of his life. She had since learned that he was removed from his biological mother at the age of 2 (abuse/neglect), placed back with her 6 months later, and removed again at the age of 4

(physical abuse); after that, he had been in six foster care placements by the age of 8. He was finally placed with his grandparents, who had not known his previous whereabouts because of their estranged relationship with his mother. His grandmother recounted reports of severe neglect, physical abuse, and "suspected" sexual abuse. His mother had abused drugs and had a nearly constant flow of men in her apartment. He had also been removed from one foster care placement due to physical abuse in that home. Neither Frankie's grandmother nor Frankie himself knew who his father was. I then asked whether my client had been in therapy before and was stunned to learn that he had not.

When I met Frankie a few days later, he was quiet and made little eye contact. I asked him whether he knew why he had been brought to see me. He shook his head; he then said he had overheard that it was about what he did to his cousin, but his grandfather "just told me to get in the car because we have an appointment." The two did not speak on the way to my office. Three sessions later, I tried to administer an assessment task designed to ascertain feeling states before, during, and after the sexual behavior problem. Frankie was starting to become comfortable with me and the play therapy setting, and to look forward to our time together, but he quickly shut down when I introduced this task. He was sitting on the floor, drawing; he put his head down and did not speak for a few minutes. I put the task away and sat with him, silently. I then offered, "This is hard stuff. I know you were hurt by a lot of people when you were even smaller than your cousin. I also know that no one helped you back then. In fact, they kept hurting you." Frankie continued lying on the floor silently, but he was clearly listening. "So I'm wondering how it feels that you are coming to see me because you hurt someone, not because you were hurt. . . . Where were all these people when you were getting hurt?"

He nodded, and then immediately started crying. I knew then that I was not going to gain his investment in preventing harm to another child until his trauma history was addressed. I postponed the referral request (to address the sexual behavior problem) and began pursuing an integrative, family-focused approach—starting with establishing safety in the home, educating Frankie's caregivers, and debunking myths about what the sexual behavior would mean about him and for him as he matured. Subsequent treatment included an emphasis on his victimizing behaviors, after he had an opportunity to process the origins of the sexual behavior problem (his own abuse).

Consensus-Based Area 2: Active, Direct Caregiver Involvement in Treatment

Outcome studies consistently identify caregiver involvement in treatment (i.e., joint parent–child sessions, separate groups for parents and children, and/or parent supportive therapy) as the program component most strongly associated with reducing sexual behavior problems in young and school-age children (Chaffin et al., 2006). In fact, Silovsky et al. (2012) assert that "current practices of treating children with sexual behavior problems as the primary problem in individual therapy or in inpatient or residential care facilities without significant caregiver involvement during treatment or aftercare are brought into question by these results" (p. 406). Friedrich (2007) has emphasized the importance of primary relationships in both the origins and treatment of these problems:

> These children first learn to relate in a disturbed manner, and subsequently use this model of relationships in their interactions with other children. Altering the first model of relating can make a difference in how these children will relate to others, and I believe this is the most efficacious form of intervention. (p. 4)

The treatment research summarized in Chapter One links both the short- and long-term effectiveness of therapy for sexual behavior problems to the participation of a parent or active caregiver. As we have noted in that chapter, the caregiver involved in treatment can be a biological parent, a kinship caregiver, or a foster parent. The preference is for a caregiver who is actively involved in the child's current daily life—ideally, a current primary caregiver who will retain full caregiving responsibilities for the foreseeable future. This caregiver must be able to stabilize the child's home environment and address contributing/maintaining factors as recommended by Chaffin et al. (2006) and Silovsky et al. (2012). As with other severe behavior problems, in order to reach the goal of reducing the intensity and frequency of the problem behavior, it is also critical to create consistency across the child's environments; this will enable the caregiver to "support and reinforce adaptive behavior, teach appropriate behavior, and provide developmentally appropriate consequences to behavior problems" (Silovsky et al., 2012, p. 406).

The more robust programs examined by Chaffin et al. (2006) include an active caregiver component. Whereas some involve caregiver

support or caregiver-mediated approaches (e.g., parent skill training), others have parents/caregivers serve as active participants or partners in their children's treatment (Brestan & Eyberg, 1998; Deblinger & Heflin, 1996; Hembree-Kigin & McNeil, 1995). Chaffin et al. (2006) suggest that the most effective treatments take a focused, goal-directed approach to sexual behavior problems and educate caregivers in practical behavior management and relationship-enhancing skills (e.g., as described by Patterson et al., 2002).

Across those effective treatments reviewed by Chaffin et al. (2006), the use of the following caregiver-focused components was found: clear explanations and directives for behavior modification; specific praise for desired behaviors and attention to positive behaviors; time out as a consequence for younger children; logical, natural consequences with older children; and promotion of parental warmth, consistency, and sensitivity. In addition, direct and active caregiver involvement in outpatient treatment supports caregivers in establishing safety and supervision guidelines; monitoring for adherence to those guidelines (ongoing assessment of risk to other children, including siblings); and, once again, working to create a safe and nonsexualized environment for the children being treated. Concurrent or collateral sessions for caregivers, in-home family therapy, and parent–child dyadic sessions are some specific approaches for gaining and fostering caregivers' involvement in treatment (Chaffin et al., 2006). In randomized trials, two group therapy approaches (Bonner et al., 1999; Pithers & Gray, 1993; Pithers et al., 1998) included active caregiver involvement within the children's group and/or in a separate parent support group, as noted in Chapter One.

Active caregiver investment in treatment provides opportunities to educate families about the need to revise rules about sexual behavior and revisit expectations around boundaries (see Form 5.1 at the end of this chapter). Within dyads, or in separate sessions, treatment is furthered when clinicians can directly address expectations for children's behavior and emphasize caregivers' need to actively promote respect for privacy and modesty among all family members—not only in order to create a nonsexualized environment (Chaffin et al., 2006), but also to begin to model and practice more appropriate expression of needs and emotions.

Clinical Illustration

I (J. A. S.) worked in a group with a 6-year-old girl, Molly, whose mother suspected sexual abuse by her father (prior to the age of 4½ years).

Molly had participated in trauma-focused individual therapy prior to placement in a group with similar-age peers who presented with sexual behavior problems. Molly was referred for specialized services following her mother's unsuccessful attempts to contain or redirect Molly's masturbatory behaviors at home and school. School reports included "excessive rubbing against her chair, with refusal or inability to stop when redirected." The mother reported that Molly often masturbated at home with the same intensity and inability to be redirected: "She goes into this zone, puts her hand down her pants, and it's like she can't hear me when I tell her to do that in private." Molly's mother was very anxious and concerned about these behaviors, and eager for guidance on how she could assist and support her daughter emotionally while directly addressing the behavior, which seemed to affect Molly's self-esteem and her academic and social development.

Molly and her mother entered concurrent group therapy. During the first phase of treatment—establishing safety; defining and establishing boundaries; and reviewing and resetting family rules about privacy and modesty—Molly's mother received psychoeducation about normative and atypical sexual behaviors, and was provided with concrete parenting strategies to help Molly at home. Armed with this information, Molly's mother was able to advocate for Molly and to request other "helpers" at school (the school counselor was chosen as the most available, empathic, and willing person). In the child group with similar-age peers, Molly's "touching problem" was named and discussed in a developmentally appropriate way. The way her touching problem affected others was framed as a boundary issue: Molly was told that touching of private parts was a behavior that needed to be kept private, because it created uncomfortable feelings for those around her. The problem was also framed as an issue that "gets in the way" or "gets me in trouble." The group members talked openly about how their touching problems made it difficult to make and keep friends, and caused them to feel weird, bad, or different. Sexual feelings, particularly stimulation when sexual body parts are touched, were framed simply as natural physical responses.

Developmentally appropriate examples about how different body parts respond to touch (or the idea of touch), and how those responses are natural and predictable, were provided to Molly and her peers. For example, I offered:

> "When the doctor hits your knee [I demonstrated] to check your leg reflex, and you 'kicked,' is the kicking 'bad' or 'wrong,' or just

what bodies do? That's right. Bodies do what bodies do, and no one would feel embarrassed about having that reflex. No one would say, 'I *can't* believe her knee did that. How weird.' Because the body did what it was supposed to do. It's the same with private parts. It's a reflex that has a good feeling."

When Molly's experience was normalized, she was able to start seeing herself as someone who had a "touching feeling" that sometimes overwhelmed her—a problem that she could learn to manage. We then taught Molly that her job was learning how to identify and shrink the problem feeling so that it was not acted out in her behavior. The Affective Scaling Worksheet and the Body Thermometer (Forms 5.2 and 5.3, respectively, at the end of the chapter) were used to help Molly grasp these concepts.

Molly was much more interested in hearing how her peers shared the same problematic feelings and behaviors than in my own education about body parts. Group members talked about the places and times they could explore their private parts, and Molly and her mother learned that most children explore their bodies, but that most kids after the age of 6 learn to touch private parts out of others' sights.

Next we began to examine the origins of the touching problem, so that the intensity of Molly's feelings could eventually be affirmed and understood ("Kids whose private parts are touched inappropriately often have bigger touching ideas and touching problems than those kids whose private parts are respected"). New boundary rules for the family were created (in parent–child dyadic review), and Molly's mother learned how to redirect Molly while acknowledging Molly's distress in those moments. Together, Molly and her mother (like the other children and parents in the parent–child group review) created specific plans for home and for school. Molly's mother was her "at-home helper," and the school counselor mentioned earlier was her "at-school helper."

Specific helpful interventions were also discussed and practiced at home. For example, Molly's increasingly empowered mother more confidently approached Molly when she started masturbating at the table or while watching television. Molly was helped to notice that the touching feeling had grown to the point where it made her mom feel uncomfortable, and that she needed to stop touching in public. Molly was encouraged to find a private place, and she soon began to understand that touching in front of others was inappropriate. Molly was able to accept this limit because her mother had also told her that she understood how

these thoughts and behaviors were related to past abuse. Molly and her mother worked on ways to "postpone" touching (setting a 5-minute timer while doing something active together, then revisiting the feeling to see whether it had "grown" or "shrunk" following the activity or distraction). They had practiced using Forms 5.2 and 5.3 twice during each session, so the dyad could now easily and immediately convey the intensity of the feeling. That is, Molly could say, "My touching feeling is a 3 (I want to touch)," or her mother could say, "Looks like your touching feeling is growing from a 4 to a 5. Let's do something together and see if it shrinks after a few minutes." Molly was starting to see her mother as an ally, and her mother was becoming an active and knowledgeable partner rather than a helpless observer of her daughter's maladaptive coping. The mother's anxiety was visibly reduced by the end of this first phase of treatment.

It is important to note that primary caregivers and clinicians discuss the caregivers' thoughts and feelings about masturbation and decide together on the primary messages to send children. On occasion, caregivers believe that masturbation is sinful and cannot tolerate giving their children a message that it's OK to engage in it, either in public *or* in private. In these cases, we help the caregivers set the limits they wish to set, and we may take some time to discuss with our clients how they think or feel about the limits that have been set at home. When we don't have a consensus from caregivers in a group about how to approach this subject, clinical work may be done in individual sessions with children.

In the second phase of Molly and her mother's treatment, Molly and her peers completed play-based activities designed to externalize and contain the "touching problem" (via sand therapy), to help the children learn and practice impulse control (via CBT strategies), and to help them gain insight into the origin and maintenance of the problem. During the sand therapy task (externalization and containment), Molly chose a miniature mermaid (a miniature she often used in her sand trays during individual therapy) to represent her "touching problem." The mermaid was placed in the center of the sand tray (each child had her own small sand tray and set of miniatures to choose from). With her mermaid in the center of the tray, Molly stated that she had chosen it "because I have to squeeze my legs tight together so I don't touch." Molly and her peers were then given this directive: "Now choose miniatures that can help the touching problem, or things that can be used to keep the problem small." Molly chose four miniatures and placed them around her

mermaid miniature. She selected a parent figure ("my mom"); a stop sign ("I can do it later"); a fence structure around the mermaid ("so it doesn't go anywhere"); and a bicycle ("I can ride my bike").

In the parent group, Molly's mother completed a similar sand therapy project in which parents were asked to choose a miniature for their child's touching problem, as well as miniatures to show how they could help keep the problem contained. Molly's mother chose a miniature of a small, sad child (sitting with her head down, withdrawn) for the problem, and five miniatures to show how she could be Molly's helper to keep the problem small: a book ("because I'm learning better ways to help"); a mother–child figure ("because I will always love her no matter what"); a key ring ("I can give her boundaries and structure"); a small toy ("lots of things we can do together when the touching feeling grows"); and a mailbox ("I want her to know she can always talk to me").

After children and their primary caregivers work in separate groups with their peers, they come together to have an opportunity to share what they have worked on. When Molly and her peers joined the adults' group, they were all eager to share their sand trays with their caregivers. Molly sat next to her mother, and the two shared "as much or as little as they wanted" about their projects. Just like most kids in this type of treatment, Molly was proud of her sand tray, but even more eager to hear what her mom had to say. Molly's mother went through each miniature and explained how she was ready and willing to support Molly lovingly, so "you don't ever have to feel sad alone. With all these things, and your ideas too, we will keep this problem small." I remember Molly giggling and her mother tearing up as the two noticed how their collective strengths, resources, and tools overpowered the "problem," which was now named, miniaturized, and placed in a container that they could both see was full of resources.

Consensus-Based Area 3: Psychoeducation and CBT-Focused Interventions for Direct Management of Sexual Behavior Problems

CBT-focused interventions and psychoeducation for children with sexual behavior problems and their caregivers constitute a third treatment area that has received support across studies of effective treatment programs for children under the age of 12 years. This area of treatment includes teaching coping skills, providing skills to regulate affect,

helping children with self-control and problem-solving strategies, and providing direct interventions (such as "stop and think before acting"). According to Chaffin et al. (2006), "Although short-term outpatient CBT . . . may not be the best option for each and every child with [sexual behavior problems], the findings do suggest that short-term outpatient CBT approaches, with appropriate parent or caregiver involvement, can be expected to yield excellent and durable results in most cases" (p. 16).

As noted earlier, children with sexual behavior problems have been successfully treated with trauma-focused CBT (TF-CBT), which is a treatment for the effects of trauma (specifically, child sexual abuse) and includes specific components for sexual behavior problems (Cohen & Mannarino, 1996, 1997; Cohen, Mannarino, & Deblinger, 2006; Deblinger, Stauffer, & Steer, 2001; Stauffer & Deblinger, 1996). According to Silovsky et al. (2012), such treatment has been found to be more effective than the passage of time, dynamic play therapy, and nondirective supportive treatment.

As emphasized by the ATSA Task Force (Chaffin et al., 2006), the cognitive and social aspects of child development must be taken into consideration by clinicians who are integrating CBT into specific treatment approaches for children with sexual behavior problems. For example, younger children may be less able than older children or adolescents to comprehend and apply cognitive coping strategies; as illustrated above in the case of Molly, they may have learned to rely on behavioral strategies such as touching their own genitals for self-soothing purposes (White, Halpin, Strom, & Santilli, 1988). Therefore, it is more appropriate for developmentally or chronologically younger clients with sexual behavior problems to be actively redirected by trusted adults to use alternative coping skills that are simpler, less reliant on cognitive processes, and more concrete, as described above in Molly's case.

In addition, young children's developmental limitations may compromise the sorts of cognitive processes involved in initiating and maintaining a sexual behavior/misbehavior (Chaffin et al., 2006). These young clients are much less able than adolescents (and certainly less able than adults) to engage in planning, grooming, rationalizing, or ignoring/recognizing cognitive distortions and "thinking errors" (often key concepts for adolescent and adult offenders' treatment programs).

> Thus, typical adult sex offender treatment concepts such as learning about a cycle of sexual behaviors or correcting elaborate cognitive

> distortions are far less applicable, if not inappropriate, for young children. Children have shorter attention spans and more limited impulse control. In contrast to some adult sex offenders, childhood [sexual behavior problems] are more likely to be impulsive rather than compulsive. (Chaffin et al., 2006, p. 19)

In addition, young children's cognitive age is suited to learning simple or concrete rules about sexual behavior, but they may not grasp the abstract reasons why such rules are important. Young children learn better by concrete, simple demonstration, with opportunities for practice and consistent reinforcement, than by discussing concepts and applying these to hypothetical or abstract situations. Therefore, effective interventions for younger children emphasize modeling appropriate behaviors; setting clear external limits; and practicing new, acceptable, or appropriate behaviors across the children's environments (e.g., home, school). In addition, expressive therapies, such as art or play therapies, may enliven and engage children in meaningful introspection and change (Drewes & Cavett, 2012).

For children over the age of 10 who have sexual behavior problems, abstract principles are becoming more accessible, and hence some more sophisticated cognitive coping strategies can be introduced. Nevertheless, their understanding of abstraction is still far less than that of adolescents or adults (Chaffin et al., 2006; Silovsky et al., 2012).

As noted earlier, psychoeducation of both children and parents is a desirable and necessary component of treatment of children with sexual behavior problems and their families. However, the content of psychoeducation may vary from program to program. It appears, for example, that behavioral models of parenting are often incorporated into CBT programs (e.g., a focus on behavioral conditioning). Other parenting models, such as Child Parent Relationship Therapy (Landreth & Bratton, 2006), may also be helpful and easy to integrate.

Inevitably, parent/caregiver psychoeducation will be guided by the orientation of program providers, but guidance is currently available with adequate examples of content areas (see, e.g., Blaustein & Kinniburgh, 2010).

We have created and implemented a program called the Boundary Project (described briefly in Chapter Six). Our program incorporates the content areas discussed in the remainder of this chapter into groups for parents and other caregivers, and we have articulated and prioritized treatment components.

SUGGESTIONS FOR WORKING WITH PARENTS/CAREGIVERS

Working with parents or other primary caregivers is generally among the most critical aspects of any general child-focused work; it is especially relevant and necessary in work with sexual behavior problems. The reasons for this are clear: Young children are greatly affected by their primary caregivers' affective style and language; caretaking and nurturing; and limit setting, supervision, and guidance. If any of these areas are compromised, children can become affectively agitated or constricted, attention-seeking or withdrawn, and they can act out in order to obtain the structure most associated with children's ability to develop internal controls and self-regulate. Simply put, children develop their psychological, social, and emotional health contextually, and they are dependent on adults' healthy, empathic, warm, and informed caretaking responses. When parents or other caregivers are themselves dysregulated, are unable to take care of their own needs, have ambivalent or negative feelings about parenting, or have limited views of their own parental capacities or competencies, children suffer the consequences. In many ways, children reflect their environments. Severely traumatized children who have suffered intense, acutely painful experiences can nevertheless be positively influenced by stable, healthy, attuned primary caregivers. Conversely, distanced, conflicted, uncertain, or self-involved caregivers can have a negative impact on or interfere with the treatment outcome of abused children.

Working with parents or other caregivers of children with sexual behavior problems is remarkably challenging because these adults often have myriad feelings about the behavior problems, including confusion, worry, shame, guilt, or distress. These feelings can cause them to hide, deny, or minimize their children's behavior. Many caregivers fear other people's assumptions, judgments, possible rejection, and/or other reactions elicited by sexuality in general and children's sexual behavior problems in particular.

The components of treatment for parents or parental figures of children with sexual behavior problems include engaging the parents/caregivers in treatment; securing their cooperation; providing psychoeducation; obtaining their agreement to provide supervision; offering clear directives about parental responses; strengthening the parent–child relationship; and encouraging role modeling and co-regulation. In our Boundary Project model, these treatment tasks are accomplished within the context of a structured assessment process; a parallel treatment

format for parents/caregivers and their children; and provision of a comprehensive, structured, family-based program.

Engaging Parents/Caregivers in Treatment

The first and most important task in working with parents or other primary caregivers is to engage them and obtain their investment in the therapy process; they must be convinced that their child's positive outcome depends on their participation. Depending on a clinician's theoretical orientation and approach, the child may be seen alone, in conjoint parent–child or sibling sessions, or in full family therapy sessions. Often caregivers are under the impression that since the child is the one with the identified problem, the child is the only client in therapy. Although direct clinical interventions with children who have developed particular behavioral problems is most certainly indicated, treating the family system (in other words, providing contextual or relational interventions) is usually considered not merely germane but critical to the success of treatment.

As we have noted in Chapter Four, a clinician conducts a comprehensive intake to obtain developmental and psychosocial information—in particular, to learn about the type and persistence of the sexual behavior problem, when it began, how it was discovered, where it was or is observed, and what solutions have been attempted. At one point, caregivers are invited to collaborate in the formation of treatment goals and objectives. The extent of the "buy-in" they demonstrate to the therapy process, and their stated willingness to follow clinical directives, are usually respectable predictors of positive outcome.

There are several challenges to overcome during assessment and the early sessions of treatment, because parents or other primary caregivers of children with sexual behavior problems may view therapy as a chore, an obligation, or an external requirement (e.g., it may be mandated by a school as a prerequisite for a child's return). Often the referral of a child with such a problem occurs because the child's behavior is a concern to someone in the child's life—be it a foster parent, a teacher or other school staff member, a day care provider, or the parent of another child who has disclosed the problem. The referral can also come from a court or a child protection or probation agency, in which clear mandates have been established for compliance with treatment. In addition, we have seen a number of situations in which blended families encounter inappropriate sexual acting out by one youngster against another; indeed,

personal boundaries may be unfamiliar, unset, unclear, and/or confusing among children in such families. In these cases, family members can feel pitted against one other and may feel as if they need to take sides. The parent of the child with an identified sexual behavior problem may want to minimize or explain away what has occurred, while the parent of the child who may have been victimized may feel outraged and frightened. One parent may thus be more supportive of therapy than the other.

Engaging parents/caregivers who are in crisis, and who on top of that are feeling compelled to receive services they don't understand or value, is the first order of business. Over the years, we have found some areas of greater success, and we pass these along with humility—not as all-inclusive, but as a basis for your consideration.

Joining has always been an important first step. I (E. G.) can honestly say that as I listen to caregivers' stories, I focus on anything they say that I can empathize with and respond to with sincere validation. I often make affirmative statements about my understanding of their current plight—for example, "I know how you feel. I hate doing something that someone else is telling me I have to do." I also make positive and true statements such as "No one likes to be told that they don't understand their children," or "Sounds like you've got some great ideas about what will help, but no one is listening." I make sure that I am respecting caregivers' expertise about their own child, and I ask them to tell me what their ideas are about what might have precipitated the concerns. My most often-repeated statement is "I need your help to help your child." I also reassure caregivers that their love and concern for their child are obvious and necessary to successful therapy outcome.

I also help parents/caregivers focus on how the sexual behavior problems are a predicament to them at this moment. They might initially focus on the fact that their child has been suspended or expelled from school (this even happens to preschoolers who exhibit sexual behavior problems, even over very minor things such as trying to kiss classmates), or that their adult friends are forbidding play dates between their children. It's important for clinicians to try to address the problems that caregivers have in the forefront of their minds first, regardless of what these are. If clinicians can establish themselves as people who can provide real help, they are much more likely to elicit receptivity to more general clinical feedback.

The most useful approach is to convey clinical willingness to be of assistance by providing purposeful feedback about how parents or other caregivers can provide guidance and limit setting within the context of a

warm and predictable parent–child relationship. Caregivers of children with sexual behavior problems often need to express their underlying fears. Most typically, these adults worry that their children will grow up to be adult sex offenders and/or will grow up to be homosexual (if the sexual behavior problems are occurring with children of the same gender). They may also harbor fears that these early sexual interests in their children could signal the development of promiscuous or otherwise deviant sexual behaviors. There is a great deal of emotionally charged misinformation about childhood sexuality, which makes the provision of psychoeducation a required element of therapy. Clinicians are well advised to inform themselves about the latest research on sexual development in children, so that they will be better able to provide some general guidelines and directions not only about contemporary normative sexual development, but about ways to understand the emergence of what might be considered non-normative or sexual behavior problems. (Incidentally, it seems paradoxical that in a country such as the United States, which appears to have an intense focus on sexuality in general, factual information on childhood sexuality remains elusive.)

"Therapeutic engagement" is the process of listening, of empathizing, and of trying to understand the parents'/caregivers' point of view, no matter what it may be—a progression of connecting with the clients and developing a respectful and helpful relationship where trust can grow. After the engagement phase, treatment goals and plans are articulated, and interventions are selected to advance those goals. During treatment, clinicians make more direct efforts to change rigid thinking patterns or clarify cognitive errors in thinking—but only after ensuring that the clients will be receptive to clinical guidance, not when they are feigning compliance or trying to get themselves stabilized in an unfamiliar therapy situation. Engagement is probably the most pivotal factor in clinical work, and once it is established, challenges can be met with less difficulty.

Securing Parents'/Caregivers' Cooperation

As mentioned above, engagement initially overrides other clinical interventions, especially during assessment. However, once a clinician has gathered data suggesting that caregivers' perceptions and attitudes are negatively affecting a child or limiting necessary support to the child, the clinician needs to challenge these adults gently in the hopes of creating more flexible responses.

Clinical Illustration

I (E. G.) worked with a father who came from a country where male strength and self-reliance were highly valued. This father had little trouble with the fact that his son had aggressively forced himself on top of a girl and humped her while holding her mouth shut. I remember him saying that "boys will be boys," and that "in this country [the United States], everything is exaggerated; nothing is just normal." I listened with interest to him talking about normative sex play in his country, and I suggested to him that childhood sexuality appears to be the same in most countries: It is not talked about publicly. He agreed that this was true when I asked him how he himself had learned about sexuality. Eventually, as he became more and more relaxed about our conversation (I had purposely avoided arguing with him or taking an opposing position at this time), I asked him to come up with times that he himself had engaged in normative sex play with peers; he had many examples. I listened intently without much comment, and this man enjoyed recalling his youth freely. When he was finished, I noted that he had described a lot of activities, but that I had not heard him describe covering someone's mouth so that they wouldn't yell or telling someone that he would kill them if they told about the activity. He looked stunned and was unable to offer a response (he was, thankfully, at a loss for words).

We had a few more appointments, now clearly with mutual trust and empathy. These enabled us to have a discussion of some beliefs that led the father to reject his son when the son admitted to having been sodomized by an older boy against his will. When the father found out about this, his behavior changed toward his son. He confided in me that he had lost respect for him, that he now saw him as "weak" and "passive," and that his wife was to blame for this softness. Once his son was able to admit to his parents that he had indeed been molesting the (much younger girl) in his neighborhood, the father appeared to take pride in the fact that the boy was sexual with a girl, not a boy. "You see," he insisted, "that was more normal than letting a boy overtake him and do with him what he wished."

Clinical dialogues with this family became very difficult at times, as I tried to explain child sexual abuse to the father and as I tried to alert him to the fact that his rejecting behaviors affected his son more than he knew. I emphasized the fact that he was in a unique position to help his son; that he was someone the son completely admired; and that he alone had a significant contribution to make to his son's development and to

his son's future. This seemed to work, partly because the father had felt shame about his son and needed to feel valued by the professionals now treating his family, and partly because the father's role had been challenged when he was court-ordered to attend therapy. He seemed reassured when I elevated his status as a helper, and he responded accordingly. Once he was convinced that he alone had the power to help his son heal and move on from the abuse, the father began to relax in his attitudes. He even acknowledged that his son's abuser was indeed that! The abuser had isolated his son, applied brute force, threatened him, and hurt him physically and emotionally.

Although the father never shifted his view about crying (a sign of true weakness to him), eventually he was able to listen to his son ask for forgiveness for not being able to resist his rapist. (This seemed to be a critical request from the child's point of view, akin to a kind of confession. This child articulated this question without feeling that he needed forgiveness, but more out of respect for his father and their culture.) The father put his son's head on his shoulder (as they sat together on the couch) and softly said, "It's OK, son, that boy took advantage. He picked someone who was much smaller and younger. He was afraid to pick on someone his own size. He is weak to fight like that." The father also heard that initially his son had kicked the older boy and run from him, and the father gave him praise for that also. "Good for you, kicking that boy hard. Good for you, bruising him up. You did good, son; I am proud." Only this boy's father could give him the gift of letting him know that he had not disappointed his father and that the father was not permanently ashamed of him. For his part, the father was able to find a place of forgiveness through having the opportunity to explore all his reactions freely, without being told they were unacceptable. He was also receptive to being given his "proper place" by his son as someone who could restore his son's sense of balance and as someone who had the ultimate power to forgive. Importantly, the father confided that "My culture thinks one way, and sometimes now I think the other," acknowledging that some of his beliefs had been challenged and he had developed a more flexible understanding of the values instilled in him during childhood. He also acknowledged that his son was being raised "with the good and bad of the United States"—an influence that he had not had growing up.

Working across cultures requires sensitivity to parents'/caregivers' cultural values, while challenging their origins and exploring them in a new context. Unique situations may require revisions to previously held

beliefs. In exploring childhood sexuality with parental figures, it is quite important for them to articulate their cultural context, given that many perceptions and beliefs are formed early and may not be challenged until specific situations emerge in a person's own life. These conversations need to be conducted in a nonpolarizing way, and yet clinicians may need to intervene with research findings about cultural mores as well as cultural history. Clinicians are advised to explore the history of childhood at large and to integrate some of what we know about this history into a provocative therapy dialogue designed to cause introspection. Most caregivers are shocked to hear about an ancient Roman law that gave parents the right to sell, abandon, mutilate, or otherwise dispose of their offspring, or that the practice of infanticide was practiced routinely as a tool for gender selection or population control. Regardless of which culture is being discussed, these tend to be fruitful dialogues.

Providing Psychoeducation on Issues Relevant to a Healthy Parent–Child Relationship

Early clinical efforts that engage family members in a therapy relationship, elicit meaningful parental investment in therapy, and gently challenge old attitudes and beliefs may earn the clinician the right to provide psychoeducation. Earning the confidence of clients is a necessary prerequisite to offering them facts, concepts, approaches, and guidance. If purposeful efforts are not made to earn this right to be heard and to have their guidance valued, psychoeducators can work very hard to give their best advice and directives—only to have caregivers tune them out, ignore their advice, and generally look the other way.

The best way to earn the right to be heard is for clinicians to afford others the same respect that they want themselves as teachers or guides. It's important to know what parents or other primary caregivers want to hear about, what they think is important, and what they might find particularly helpful in their situation. Giving them a chance to state their needs (and then address these) is necessary and fruitful. After parental needs are understood and are used to alter or redefine a psychoeducational agenda, trust is solidified and receptivity increases. In group treatment, every group sets a slightly different agenda, and yet psychoeducation for caregivers of children with sexual behavior problems usually includes a core set of topics that cannot be omitted. Over time, as these adults come to view the clinician and the treatment as resources in their lives (as opposed to an inescapable obligation or another required step to

regain control), they can more readily reflect upon, accept, and integrate the information that is delivered.

Psychoeducation for parents/caregivers of children with sexual behavior problems will touch on the topic of childhood sexuality by necessity. However, it must also include contextual information about improving or enhancing parent–child relationships.

Obtaining Parents'/Caregivers' Agreement to Provide Supervision

One of the core beliefs in work with children who have sexual behavior problems is that the children's internal controls are not working sufficiently to override their inappropriate behaviors, whether these behaviors are impulsive or planned. Because of that core belief, it becomes crucial to ensure that a child's parents or other primary caregivers are willing and able to provide mechanisms of constant supervision; this supervision becomes the child's temporary external controls. It is also important to define "supervision" as within-eyesight supervision at all times. Caregivers will find this quite demanding of their time and a real departure from their regular everyday routines. And yet obtaining a firm contract about this, while children are in treatment, is a critical key to success.

A parent who had participated in our program for about 3 months had begun to relax her supervision as she took great comfort in changes in her son's behaviors, his open sharing about his sexual behavior problems (a truly remarkable change, given his initial denials), and her growing trust that the problem was being addressed and had shown itself responsive to interventions and supervision. She was stunned, therefore, when her daughter came to her while she was cooking and said that her brother had come into the bathroom while the daughter was in there urinating: "I told him to leave, Mom, I told him, and he wouldn't!" When this mother approached her son with great concern and frustration in her voice, the boy said, "Well, she's supposed to be locking the door all the time." He then added that although he stood at the door when his sister was yelling for him to get out, he never entered the bathroom and thought his sister's reactions were funny. This child appeared to be telling his mother that he still needed external controls (he needed to be watched, and his sister needed to lock the door) in the home. The mother heard the message "loud and clear," and went back to her more

structured and vigilant approach to supervision until her son developed better internal controls.

Offering Clear Directives about Parental/Caregiver Responses

Probably one of the most consistent issues that we see in parents/caregivers of children with sexual behavior problems is the adults' own discomfort with the area of childhood sexuality, their reluctance to approach the topic head-on, and their confusion about what to say or do when confronted with their children's inappropriate behaviors.

This hesitancy about addressing childhood sexual problems directly is firmly anchored in a lack of education and preparation for parents/caregivers in this general area of life. Parental figures typically struggle to find the motivation to talk with their children about normative sexual development, and even when they feel obligated and compelled to talk with them, they don't know what words to use or what messages to send. These difficulties can increase when adults are suddenly confronted with behaviors that cause them to feel concerned or ashamed. Children and teens continue to get most of their information about sexuality from conducting their own "research" (e.g., on the Internet), from self-discovery, from peers, or from other avenues of information. Rarely do adults provide enough information regarding normative sexual development, and the emphasis in what information they do provide seems to be on what *not* to do versus what is appropriate and expectable.

Because of this situation, one of our earliest interventions is to provide language that parents/caregivers can use to make the sexual behavior problems explicit, followed by ideas for setting limits and consequences. Clearly, it is important for them to provide alternative behaviors as well. Clinical role playing is often quite helpful, so that caregivers can make attempts to communicate clearly and remain aware that their nonverbal communication also needs monitoring. They need to recognize that their words are not the only information they are conveying; they also communicate with their tone of voice, intonations, facial expressions, and physical posture. Getting caregivers to be firm and gentle at the same time can feel quite challenging to them. Clinical demonstration as well as practice can help this seem more natural and increase their confidence in how to respond.

Given that the topic of childhood sexuality in general, and sexual behavior problems specifically, can arouse strong negative or conflictual

thoughts and feelings, among the earliest topics to be openly addressed are normative sexual development and what is known about baseline behaviors of children across the developmental span. Most of the time, caregivers are surprised and relieved to learn that "normal" children also have overt sexual curiosity and behaviors.

Strengthening the Parent–Child Relationship

The parent–child relationships that we have seen in our clinical practice over the years have included widely varying degrees of attachment, emotional connection, positive regard and respect, and mutual nurturing. In other words, some of the relationships we encounter are "temporarily under construction" and have obvious areas that require repair. Sometimes vulnerabilities that existed before the emergence of sexual behavior problems are exacerbated by the stress or crises elicited by children who develop or maintain sexual behavior problems. At other times, preexisting relationships may have been strong, but they come under siege from the sudden and distressing loss of trust, respect, and positive regard between family members. Sexual behavior problems in children can emphasize vulnerabilities in parent–child relationships or can cause them to emerge. But no matter what the preexisting state of a parent–child relationship (or sibling relationship) may be, it is important to address the relationship's foundation so that it can withstand the stress, to find areas for growth, and to support the parental figures in providing the necessary anchor for the child's emotional and psychological health.

After years of research in the field of attachment, neuroscience, successful parenting, and healthy family functioning, researchers have arrived at some basic tenets that prove useful for parents in establishing, repairing, or enhancing parent–child relationships. These basic tenets should be shared with parents throughout their treatment, in nonclinical language.

Encouraging Role Modeling and Co-Regulation

Another early topic for discussion with parents or other primary caregivers involves their affective language and expression—that is, how they talk about and express their feelings. Perhaps no other area requires such early and sustained education for children as this one. Children must learn in childhood how to identify their feelings, communicate to others how they feel, and express their feelings in socially acceptable ways. In

fact, how children learn to manage their emotions is the topic of many books and a major contributor to successful child development.

There are many possible questions about emotions, and many possible suggestions. Some beliefs about and responses to emotions are gender-based: Little girls may be held and comforted when they cry, but boys may be told to "knock it off." Others are age-based: A young infant crying on an airplane trip, although painful to hear, may not elicit judgmental responses; a 7-year-old who has a temper tantrum in the grocery store may elicit much more negative reactions from others. Parents/caregivers can be helped to examine these beliefs and responses and to consider whether reworking some of them may be helpful.

Adults are often plagued with confusion about crying (both their own and their children's). A businesswoman may feel angry at herself for crying in a meeting, because she is afraid that crying will be perceived as a weakness. A businessman who cries may also feel subjected to ridicule by peers. We all seem very affected when someone cries on television during an interview. It seems that obvious shows of emotion can elicit both positive and negative responses, and they are always topics of discussion and reaction.

An important aspect of therapy is for caregivers to feel equipped to handle their own and their children's emotions. Adults can make a great contribution by helping their children learn how to negotiate and manage their emotions, both in private and in public.

SUMMARY

The research regarding the treatment of children with sexual behavior problems and their families clearly gives us much room for optimism, as both short- and long-term treatment interventions have shown positive results. It is evident from this research that young children require parents' or other primary caregivers' full engagement and willingness to provide a positive, reparative structure, along with supervision of their children in order to provide external controls. Consensus has been reached on the following three areas for treatment: (1) therapeutic attention to trauma when appropriate (i.e., a flexible approach to integration of trauma-focused treatment with interventions focused directly on sexual behavior problems); (2) active, direct caregiver involvement in treatment; and (3) inclusion of psychoeducation and CBT-focused interventions for direct management of the sexual behavior problems. Although

psychoeducation and parenting programs can and should be incorporated into clinical interventions, psychoeducation topics are varied, and parenting models are ample. We have presented our own overview of work with parents/caregivers in the second part of this chapter.

Clinicians working with sexual behavior problems in children should stay aware of the research; be willing to incorporate new ways of engaging and eliciting the full cooperation of young children; and always remain cognizant of the need to join with parents/caregivers who may feel and express a wide range of intense emotions. In particular, engaging caregivers to make a full commitment to their children's therapy appears to be one of the most important clinical tasks, since parental cooperation and participation are directly related to positive treatment outcome.

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