
INTERVENTIONS FOR CHILDREN WITH SEXUAL BEHAVIOR PROBLEMS

RESEARCH, THEORY, AND TREATMENT

By
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and
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—Lesley Lundeberg

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Introduction

The client is Steven, an eight-year-old boy who was referred to treatment by the State's Division of Child and Family Services after he pulled down the pants of a six-year-old neighbor girl and simulated sex. During intake, his mother becomes highly emotional as she discloses a personal history of being sexually abused as a child, problems with drugs and alcohol, and involvement in several abusive relationships. Recently, the family's life has become even more stressful as she has lost her job and her most recent boyfriend has left. She is a single mother with three children. Steven has had little contact with his biological father who is currently incarcerated for dealing drugs. Steven has a long history of behavioral problems, including lying, fighting, defying authority figures, and stealing. His mother describes hostility, contention, and conflict in their relationship. She says sternly, "He is just like his father." Upon intake, Steven is hostile. He is only willing to answer a few simple questions. However, any time the subject of sexual touching arises, he hides his face with his hands and refuses to talk or make eye contact. "Do you see how he is?" sighs his mother. She then tells him to sit up, and when he does not respond, she starts yelling at him. Consequently, he starts yelling back with very colorful language. The fighting continues to escalate as the therapist ponders, "What am I going to do?"

* * *

Suzie is a nine-year-old girl who is the oldest of three children. Their father had been sexually abusing Suzie and her younger sister for over a year. The family was very private and had few interactions with outsiders. The family system is also highly religious and patriarchal. Suzie is thought to be her father's favorite. Their mother is a timid and passive woman who is suspected to have known about the abuse, but was unable or unwilling to intervene. The sexual abuse came to the attention of the authorities after the younger sister disclosed the abuse to a trusted schoolteacher. Consequently, Suzie was removed from the home and placed into foster care. Suzie is very angry about being separated from her father and frequently asks to see him. Her foster parents report she masturbates compulsively and has been observed using stuffed animals, toys, and furniture for self-stimulation. She also acts highly seductive toward older men and was recently caught trying to peek in on her foster father while he was changing his clothes. Also, during the past week, she was caught trying to sneak into the boys bathrooms in the school. The foster parents are desperate for ideas regarding what to do, saying they don't know if they can keep her in their home if things don't change. The clinician wonders, "What am I going to do?"

* * *

Alex is a ten-year-old boy who has problems with sexual behaviors. He lives in a middle class family with both parents and three younger siblings. Alex was first introduced to sex when he was seven by a same age peer in the school bathroom. It began as a simple game of "I'll show you mine if you show me yours." However, it quickly advanced to the point to which both boys would plan meetings at strategic places during recess and after school, where they would engage in mutual masturbation, oral sex, and anal sex. This ended when the school janitor caught them and the other boy was

transferred to another school. For a while, Alex's sexual behaviors ceased, but recently problems have re-emerged, including excessive sexualized talk, drawing pictures of naked people, and writing love notes to other boys in his class. Things have become very concerning as he has started attempting to entice other boys into engaging in sex acts. His mother has sought out professional help. She does not approve of his behaviors, but her biggest concern is that her son might be gay. During the initial interview, Alex is easy to engage and freely talks about his problems. He describes his first sexual experiences in detail, saying, "It felt really good." It becomes very noticeable that as he is talking, Alex begins to get an erection. The therapist becomes very uncomfortable and starts thinking, "What am I going to do?"

* * *

Debbie is a twelve-year-old girl who was referred to treatment by a court order after it was alleged that she performed oral sex on an eight-year-old male cousin during a sleepover. Debbie has a history of being sexually abused by her fifteen-year-old brother, who had Debbie engage in the same behavior with him. Her mother has her own history of untreated sexual abuse. She is known to have had numerous boyfriends and has never been able to maintain a stable relationship. Debbie has had no contact with her father who abandoned the family soon after she was born. At the time of her own victimization, Debbie was referred to treatment, but failed to make more than two sessions. Her mother cited conflicts with her work schedule as the reason. Debbie presents as being pseudo mature. She attends the intake session wearing a short leather mini-skirt, a belly shirt, mid-heel shoes, extensive make-up, and lots of jewelry. Her mother is dressed similarly. The interactions between Debbie and her mother appear to resemble that of siblings, as they giggle together while commenting on clothing, hairstyles, and cute boys. Both Debbie's and her mother's interactions with the male staff appear flirtatious. When asked about her victimization, Debbie defends her brother and blames herself for the abuse. She refuses to talk about her alleged abusive behaviors saying it won't happen again. She claims to have a fourteen-year-old boyfriend whom she recently met at the local mall. The therapist is concerned and wonders, "Now, what am I going to do?"

THE PROBLEM

Such scenarios are not uncommon when working with children who have sexual behavior problems. However, until recently, childhood sexuality was a taboo subject, not openly acknowledged or discussed. This appears to have been particularly true with regard to child behaviors that are sexually aggressive or abusive. Even in the professional community, the phenomena of childhood sexually aggressive or abusive behaviors did not begin receiving direct attention in the literature until the late 1980s.

It has taken a long time for society to admit these children exist. The societal myth that only strangers commit sexual abuse persists. In reality, the ever-increasing number of child sexual abuse referrals documents that most sexually abused children are victimized by someone they know—a parent, relative, friend, baby-sitter, or another child. The myth that children do not commit sex offenses is no longer tenable. (Burton, Rasmussen, Bradshaw, Christopherson, & Huke, 1998, p. 4)

Over the past two decades the public's awareness of childhood sexual abuse has increased. Likewise, professionals and the general public have slowly become more aware that some children engage in sexual behaviors that are problematic and abusive. Clearly, sexual curiosity and arousal are a normal aspect of child development. Also, "Children engage in an expansive array of sexual behaviors, the vast majority of which do not remotely constitute abuse (Gray, Busconi, Houchens, & Pithers, 1997, p. 269)." However, there is a growing awareness that some children become overly sexually focused and/or engage in sexual behaviors that extend beyond the realm of normal development. If left untreated, these problems can threaten the child's future growth in several developmental domains (e.g., social, emotional, sexual).

The study and treatment of children with sexual behavior problems is young. Accurate information is not widely dispersed and training is limited. Frequently, clinicians experience a "baptism by fire" when they are assigned cases similar to those discussed at the beginning of this Introduction, with no prior experience or training in treating children with sexual behavioral problems. Consequently, "Clinicians who treat these children must often rely on their clinical experiences or make developmental adjustments to treatment approaches used with adult and adolescent offenders" (Burton et al., 1998, p. 5). This can be an overwhelming and uncertain proposition for an inexperienced mental health worker. Thus, the proposed question, "What am I going to do?" is frequently on the minds of therapists working with this population.

This book was written for clinicians who find themselves entering this arena of treatment. The goal is to highlight the early research, discuss a theoretical basis for treatment, outline an integrative treatment model, and provide specific treatment activities for clinicians working with children who have sexual behavior problems and their families. We are hopeful this book can provide a foundation for clinicians, enabling them to answer that question, "What am I going to do?"

BOOK ORGANIZATION

This book is divided into three sections: Part 1 (Chapters 1 through 3) covers the research on problematic sexual behaviors in children; Part 2 (Chapters 4 through 7) discusses the theoretical bases and components in treating children with sexually problematic behaviors; and Part 3 (Chapters 8 through 15) provides an array of treatment activity interventions.

Part 1: Problematic Sexual Behaviors in Children—Current Research

Part 1 provides a review of the research on childhood sexual behaviors and issues related to children who have problematic sexual behavior problems. Chapter 1 discusses normative and problematic sexual behaviors in childhood. Research efforts to establish normative sexual behavior in childhood, sexual development throughout childhood, and factors to be considered when determining if a child's sexual behaviors are problematic or abusive are discussed.

Chapter 2 briefly examines research regarding the problematic and abusive sexual behaviors committed by children and efforts to establish a typology for children with sexual behavior problems. This discussion includes the types of sexual behaviors manifested, the child's use of grooming and coercion, whom they victimize, and the

number of victims they abuse. Similarities and differences between children with sexual behavior problems and adolescent and/or adult offenders are discussed. The authors advocate that treatment for latency age children be differentiated from adolescent and adult interventions, accounting for developmental differences. Research on the development of typology suggests that children with sexual behavior problems are not a homogeneous group, but there are similarities among various groupings. These child types differ not only in terms of sexual behaviors, but also along a variety of variables related to the child, family, and their social environment. Clinical implications of this research are briefly discussed.

Chapter 3 outlines relevant research on variables related to childhood sexual behavior problems, organized according to the four-component model proposed by Friedrich, Davies, Feher, and Wright (2003): modeling of sexuality, family adversity, modeling of coercive behavior, and child behavior. A checklist of factors to aid clinicians during assessment is provided.

Part 2: Treatment Modalities

Part 2 of this book outlines the theoretical formulation, important areas of clinical focus, an integrated treatment framework, and discusses clinical work with latency age children who have engaged in aggressive or abusive sexual behavior problems.

Chapter 4 outlines two theoretical models that appear highly relevant in the treatment of children with sexual behavior problems. The first is Trauma-Focused Integrative Eclectic Therapy (IET), developed by Friedrich (1995). The three domains of this theory (attachment, dysregulation, and self-perception) apply to children with sexual behavior problems. The second treatment model is Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) proposed by Deblinger and Heflin (1996), which can be applied to the treatment of children with sexual behavior problems. Treatment components of this model include: psychoeducation, emotional expressive skills, stress management and self-regulation skills, cognitive coping skills, gradual exposure with cognitive and affective processing, and behavioral management training for parents.

In Chapter 5, the two models are integrated into a theoretical framework to treat children with sexual behavior problems and their families. This integrated framework highlights eight areas of focus to be addressed in treatment. The first three areas of focus (safety, attachment/mobilizing support systems, and affective regulation) may require parents to alter their parenting style.

The remaining five areas of focus (cognitive distortions, gradual exposure, social skill development, psychosexual education, and self-perception/personal identity), presented in Chapter 6, focus more specifically on the child.

Chapter 7 discusses how to initiate and structure the treatment process and includes a discussion of treatment provider qualifications and training. Other topics addressed include: conducting an intake psychosocial assessment, developing treatment goals, providing concurrent treatment modalities, managing resistance, and structuring therapy sessions.

Part 3: Clinical Practice—Treatment Activity Interventions

Part 3, comprising Chapters 8 through 15, presents activity interventions that can be used to treat latency age children with sexual behavior problems. These activities are organized into eight categories: psychosexual education, safety planning, relationship skills, emotional expressive skills and empathy, cognitive coping, self-regulation, trauma narrative, and prevention planning. The function, application, and limitations of these activities are discussed, and step-by-step instructions and example dialogue boxes are provided for each activity. The treatment hand-outs provided in these chapters are also provided on a CD-ROM, which can be used to print out copies for use with your clients.

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