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CLINICAL CASE REPORT SERIES

Evidence-Informed, Individual Treatment of a Child with Sexual Behavior Problems: A Case Study

Brian Allen · Lucy Berliner

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Abstract Children with sexual behavior problems pose a significant challenge for community-based mental health clinicians. Very few clinical trials are available to guide intervention and those interventions that are available are based in a group format. The current case study demonstrates the application of evidence-informed treatment techniques during the individual treatment of a 10-year-old boy displaying interpersonal sexual behavior problems. Specifically, the clinician adapts and implements a group-based model developed and tested by Bonner et al. (1999) for use with an individual child and his caregivers. Key points of the case study are discussed within the context of implementing evidence-informed treatments for children with sexual behavior problems.

Keywords Sexual behavior problems · Child treatment · Evidence-based treatment · Treatment implementation

Introduction

Children displaying sexual behavior problems (SBP) have traditionally received little attention in the clinical and research literature. SBP is broadly defined as developmentally inappropriate or potentially harmful interpersonal and/or non-interpersonal (e.g., self-focused, public demonstration) behaviors involving sexual body parts (Chaffin et al., 2008). Although no epidemiological data are available, Friedrich (2007) reported that approximately 6 % of children presenting for mental health treatment may display some form of serious SBP. Lévesque, Bigras, and Pauzé (2012) found a 1-year stability rate of 43 % for SBP among children, suggesting that these concerns may be persistent in many cases.

Although the statistics suggest a need for effective evidence-based treatment for SBP in community settings, relatively few clinical trials have directly examined protocols for the amelioration of SBP. St. Amand, Bard, and Silovsky (2008) conducted a meta-analysis of clinical trials targeting SBP in children 12 years of age or younger and identified a total of 11 studies. Of those studies, only 4 examined SBP as the primary outcome. The other studies examined sexualized behaviors as a secondary outcome with the primary focus of treatment being on other sequalae of sexual abuse, typically posttraumatic stress. Although a trauma-focused treatment, such as Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006), can be effective for resolving SBP related to posttraumatic stress symptoms and sexual abuse experiences (Cohen, Deblinger, Mannarino, & Steer, 2004; Deblinger, Staufer, & Steer, 2001), it is generally regarded that a large proportion of children, potentially a majority of children displaying SBP, have no sexual abuse history (Bonner, Walker, & Berliner 1999; Silovsky & Niec, 2002) and a trauma-focused treatment may not be indicated.

Of the 4 outcome studies identified by St. Amand et al. (2008) focused specifically on SBP among children, all were group treatment programs. Notable among these programs is a 12-session protocol by Bonner et al. (1999) that includes techniques such as sexual psychoeducation, establishment of sexual behavior rules, and the development of self-control techniques. In addition, a parallel parent group program teaches caregivers about normative and problematic sexual development and behavior, and how to implement behavioral child management skills in response

B. Allen (✉)
Center for the Protection of Children, Penn State Hershey Medical Center, 500 University Drive, Mail Code H085, Hershey, PA 17033, USA
e-mail: ballen1@hmc.psu.edu

L. Berliner
Harborview Medical Center, University of Washington, Seattle, WA, USA

to the child's sexual behavior problems. A previous clinical trial established that this protocol was effective in reducing the occurrence of problematic sexual behaviors among children (Bonner et al., 1999). A 10-year follow-up of this clinical trial found that only 2 % of the children treated with the Bonner et al. protocol committed a future sexual offense, comparable to a group of children who originally presented for treatment with non-sexual behavior problems, such as defiance and aggression (Carpentier, Silovsky, & Chaffin, 2006).

One limiting factor of the Bonner et al. protocol, as well as the other tested treatment programs for children with SBP, is that it was developed as a group program. Given that the presentation of a sufficient number of children with SBP to make a group protocol feasible is unlikely in general clinical settings, it is imperative to demonstrate the applicability of treatment programs in an individual format. In addition, other factors such as logistical complications (e.g., time and day of the group, transportation issues) and/or caregiver or child discomfort with the group setting, may necessitate other treatment options. The Bonner et al. protocol incorporates components believed to be important for effective treatment of children with SBP (Chaffin et al., 2008; St. Amand et al., 2008), and the protocol may be applied to individual cases. This case study demonstrates the implementation of the original group protocol for the individual treatment of a child presenting with SBP. Publication of the case study was approved by the appropriate Institutional Review Board and consent was provided by the caregivers and child. Details not relevant to the clinical material were altered to protect the client's confidentiality.

Background Information

Graham was a 10-year-old boy who presented for treatment following the discovery of repeated sexual acts that he committed involving his 7-year-old sister. The sexual behavior was ongoing for approximately 3 years before his sister disclosed to her parents. Complicating the issue was the fact that Graham was adopted into the family at the age of 6 from Vietnam. Upon learning about the sexual behavior, his adoptive parents removed Graham from the home and sent him to live with his aunt and uncle (adoptive mother's sister and brother-in-law). The adoptive parents viewed Graham's behaviors as a betrayal of trust; the sister involved in the sexual behavior was a biological daughter of the adoptive parents. They described him as emotionless, conniving, and a "budding psychopath." Almost immediately after removing him from the home, the adoptive parents began legal proceedings to surrender custody of Graham and were actively seeking criminal charges. Graham's aunt and uncle contacted the clinic to begin treatment services shortly after he was placed in their care.

Mr. and Mrs. H. (uncle and aunt) willingly agreed to care for Graham. They had no other children in the home and were not particularly concerned about sexual safety issues. In addition, they believed that the adoptive parents were being unfair to Graham. They discussed how his adoptive parents would often describe Graham in overly negative terms and they were skeptical of the reasons for the parents adopting him. Although his adoptive parents often described Graham as displaying significant behavioral and emotional problems, Graham had not received any previous mental health treatment according to Graham and Mr. and Mrs. H.

Assessment

Graham presented as an intelligent, but emotionally immature 10-year-old. Since no official birth records were available, his age was approximated and he may have been younger than stated. His adoptive home consisted of himself, his adoptive parents, his younger adoptive sister, and an older adoptive brother. Graham reported significant physical discipline while living with his adoptive parents and that he was often in trouble "for things [he] did not do." He also described how he felt like the outcast in the family, as his adoptive parents did not show the same kind of anger or physical discipline to their biological children.

Graham admitted to the sexual behavior as described by his sister, and reported that it involved him exposing his penis to his sister and masturbating on her feet to the point of ejaculation. He did not report ever touching her sexual parts or that she ever touched him. No oral sex or intercourse was disclosed. The sexual behavior was ongoing since he was adopted into the home. Although no use of force was indicated by any records, Graham did admit to bribing his sister in the months leading up to the disclosure by agreeing to pay her to not talk about it.

When discussing the sexual behavior, Graham appeared confused as to why people were angry and did not understand why he was facing criminal charges. He reported that his sister never refused, she voluntarily held out her feet when the incidents occurred, and she never appeared particularly upset or disgusted. He was unable to describe how she might have felt during the incidents and seemed hesitant to even consider her reactions or thoughts.

Mr. and Mrs. H. noted some sexualized behavior in their home, including attempting to touch Mrs. H.'s breasts, and that Graham displayed poor interpersonal boundaries marked by frequent attempts to touch others in non-sexual ways. On the Child Sexual Behavior Inventory (CSBI; Friedrich, 1997), Mr. and Mrs. H noted significant concerns on the total scale ($T = 80$) and much of this elevation was directly attributable to developmentally inappropriate and worrisome sexual behaviors (Sexual Abuse Specific Indicators scale, $T = 110$). Using their own observations and reports from Graham and his adoptive parents, Mr. and Mrs. H. endorsed the following SASI items on the CSBI: stands too close to people, touches or tries to touch women's breasts, touches private parts when at home, tries to look at people when nude or undressing, knows more about sex than other children their age, and

identified the behaviors with his sister as other concerning sexual behaviors.

Other externalizing problems were also noted. Although Graham did not report any significant behavioral problems, Mr. and Mrs. H. noted hostility from Graham since he began living at their home and believed that the transition was difficult for him. He was emotionally distant, frequently irritable, and they were concerned about the externalizing behaviors he displayed at home (e.g., oppositionality, angry screaming, lying). Mr. and Mrs. H jointly completed the Behavior Assessment System for Children, Second Edition (BASC-2: Reynolds & Kamphaus, 2004), and scores suggested clinically significant problems with a broad range of externalizing problems, including aggression ($T = 77$) and conduct problems ($T = 73$), and moderate concern related to hyperactivity ($T = 63$). The aunt and uncle noted, however, that they have not received any concerns from school personnel regarding Graham's behavior.

A related source of concern for Mr. and Mrs. H. was their admitted lack of parenting skills, as neither of them had children and had not planned on raising children. In addition, the aunt and uncle stated that, prior to his living with them, they would see Graham only during family functions and did not believe they had a particularly close relationship with him. They believed they were ill-equipped to handle his emotional and behavioral problems and displayed notable anxiety regarding their responses to Graham's behaviors. Their primary discipline strategy was removing privileges, but they were unsure of multiple aspects of that process, such as the duration of the removal, the number of things to remove, or if he could be allowed to earn them back. Mr. and Mrs. H. noted that they were trying to monitor his use of the computer/internet, but did not otherwise maintain close supervision over Graham when at home. The clinician assured the caregivers that maintaining close supervision was appropriate for a child with Graham's concerns and advised them not to allow Graham to be unsupervised with any children at the current time.

When asked about his history prior to the adoption, Graham did not remember much of his time living in Vietnam other than there was little food and he was often hungry. During a trauma screen, Graham did not endorse any history of traumatic events, including previous sexual abuse. Corroborating Graham's lack of concern was his scores on the Trauma Symptom Checklist for Children (Briere, 1996). He did not identify any significant emotional concerns, although he did display sub-clinical levels of sexual preoccupation (see Table 1). This increased level of preoccupation with sexual topics is not uncommon for children with SBP (Allen, Thorn, & Gully, in press). Although Graham did not report a trauma history, the TSCC was selected as it does not ask about or require the identification of any specific traumatic events, but does assess various forms of internalizing and externalizing concerns, including those concerns more frequently associated with traumatic events (e.g., posttraumatic stress, dissociation). In addition, the TSCC is the only widely used measure that assesses a child's self-reported concerns about sexual topics.

Table 1 Outcome Data

Reporter	Measure/scale	Pre-treatment *T* score	Post-treatment *T* score
Caregiver	BASC-Externalizing composite	73[b]	53
	BASC-Internalizing composite	46	41
	BASC-Hyperactivity	63[a]	45
	BASC-Aggression	77[b]	53
	BASC-Conduct problems	73[b]	59
	BASC-Anxiety	50	42
	BASC-Depression	49	47
	BASC-Somatization	42	39
	BASC-Atypicality	46	53
	BASC-Withdrawal	40	42
	BASC-Attention problems	59	61[a]
	CSBI-Total	80[b]	43
	CSBI-SASI	110[b]	44
	CSBI-DRSB	59	45
Child	TSCC-Anxiety	47	44
	TSCC-Depression	48	43
	TSCC-Anger	52	41
	TSCC-Posttraumatic stress	56	47
	TSCC-Dissociation	56	47
	TSCC-Sexual concerns: total	61	45
	TSCC-Sexual concerns: preoccupation	69[a]	47
	TSCC-Sexual concerns: distress	54	44

BASC Behavior Assessment System for Children-2, *CSBI* Child Sexual Behavior Inventory, *SASI* Sexual Abuse Specific Indicators Scale, *DRSB* Developmentally-Related Sexual Behavior Scale, *TSCC* Trauma Symptom Checklist for Children

[a] Above "at-risk" cutoff score

[b] Above clinical cutoff score

Case Conceptualization and Treatment Planning

The assessment results clearly suggested that SBP, and other externalizing behavior problems, would be the primary target of treatment. The sexual behaviors displayed by the client with his sister, and ongoing boundary violations with his aunt and others, were of the utmost concern. Graham came into frequent contact with younger children through school, after-school activities, and in his neighborhood. Therefore, a treatment program that directly addressed SBP, while also focusing on parenting skills and the amelioration of other externalizing problems, was preferable. Given the lack of an identified trauma history for the client by either Graham or his caregivers, a trauma-focused intervention such as TF-CBT did not appear warranted. In addition, there was no indication of social learning as a possible etiological explanation for the behavior. The most plausible explanation for the SBP appeared to be poor social boundaries, poor impulse control, and potentially cognitive factors, such as repetitive thoughts

or curiosity about sex and sexuality. Therefore, the selected treatment program should be capable of addressing these potential etiological factors.

The treating clinician (BA) discussed the Bonner et al. (1999) treatment protocol with Mr. and Mrs. H, and with Graham. The clinician emphasized the active role Mr. and Mrs. H. were expected to play in each session. The participants agreed that the treatment sounded appropriate and that they would participate. The treating clinician was a licensed, doctoral-level clinical psychologist with prior training and experience in the treatment of children with SBP.

The Bonner et al., protocol was delivered with a goal of maintaining fidelity to the sequence and function of the techniques provided, but doing so by modifying the group activities for use in an individual format. In some instances, this required significant alterations, whereas in other situations the material was directly transferrable. The discussion that follows each subsection of treatment begins by discussing the goals and treatment session techniques of the Bonner et al., protocol before a more in-depth discussion of how these techniques were used in treatment with Graham. One significant alteration that deserves mention is the integration of Graham's caregivers into the individual treatment sessions. In the Bonner et al., protocol, there are separate and complimentary group programs for children and caregivers; however, given the constraints of clinical practice, specifically 50-min sessions once per week, both Graham and his aunt and uncle participated in each individual session. The clinician typically met with Graham for the first half of the session and met with Mr. and Mrs. H. during the second half of the session.

Treatment Course

Sessions 1–2

The first session of the original protocol focuses on introducing group members to one another and orienting them to the purpose of the treatment. The first session in Graham's treatment followed a similar approach: the clinician spent a majority of the period developing therapeutic rapport with Graham by allowing him to ask questions and engaging in play activities. The clinician made a point to directly discuss the sexual behaviors during the play to gauge Graham's comfort and openness in addressing this topic. He responded primarily with nonverbal head nods and did not engage in a discussion regarding the sexual behaviors. The clinician provided a brief overview of the various activities of the upcoming sessions and advised Graham that discussions of sexual topics and the sexual behaviors with his adoptive sister would be a frequent subject. He nodded in agreement.

Mr. and Mrs. H. attended the first session in a state of noticeable anxiety. They relayed the events of a recent court hearing where Graham's adoptive father specifically asked the court to remand Graham to a juvenile correctional facility. Although the court did not agree with this request, Mr. and Mrs. H. were concerned that such a sentence was possible. The clinician spent time discussing the juvenile court system, the role of the juvenile probation officer, and typical outcomes in such situations. In addition, the clinician advised Mr. and Mrs. H. that he was incapable of giving legal advice, but that it may be in Graham's best interest to request that a guardian ad litem be assigned to the case. They decided to seek legal counsel. The remainder of the session was spent reviewing the topics that would be discussed with them and Graham in future sessions, as well as reviewing safety issues. Mr. and Mrs. H. noted that they had begun to more closely supervise Graham and had talked with his teacher at school about increasing monitoring of Graham with other children. As there were no prior concerns related to sexual behavior issues at school or with children other than his sister, the decision was made to protect against any potential ramifications of identifying Graham as displaying sexual behavior problems. Mr. and Mrs. H. stated that they told the teacher Graham had "some behavioral issues" with other kids recently and wanted to make sure they did not occur at school.

The second session of the protocol focuses on teaching the child and caregivers the areas of the body considered private as well as sexual behavior rules. The clinician began the discussion by reviewing with Graham the anatomical names for the sexual parts of the body using pictures showing male and female bodies. He appeared confused and noted that he did not recall previously hearing the names. Graham briefly discussed how sex was a forbidden topic in the home of his adoptive parents and even the pictures being used in session would have elicited punishment. The clinician empathized that he was most likely afraid of asking questions about such topics for fear of being in trouble. Graham acknowledged this statement and began asking multiple questions about the various body parts and their functions.

The clinician then reviewed the sexual safety rules with Graham: (1) It is ok to touch your private parts when you are alone, (2) It is not ok to touch other people's private parts, (3) It is not ok for other people to touch your private parts, and (4) It is not ok to show your private parts to other people. Because of Graham's poor interpersonal boundaries, two additional rules from Friedrich (2007) were added: (5) I practice safe distance with family and friends, and (6) I let my aunt and uncle know if anyone does sexual things to me. Each of the rules was discussed in depth with Graham and examples of abiding by and breaking the rules were given. At the end of the session, the clinician presented Graham with multiple hypothetical situations (e.g., a boy at school asks you to go in the bathroom and show him your penis, your uncle gives you a hug when you are feeling sad), and Graham was tasked with identifying if any sexual safety rules were broken. If so, he was asked to identify what rule was broken. Graham did well at this exercise, but some responses required further discussion and greater clarification of the rules.

The clinician reviewed the sexual safety rules with Mr. and Mrs. H. He discussed Graham's responses during session and emphasized the importance of creating an atmosphere where Graham can

freely ask questions and not believe that punishment will follow discussions of sexual topics. Mr. and Mrs. H. understood and agreed. The clinician suggested that they make efforts to point out to Graham in the coming week any sexual safety rules that they notice him violating, especially interpersonal boundary violations, and to praise his compliance with the sexual safety rules. The clinician asked if Mr. and Mrs. H. believed that any additional sexual safety rules were needed in addition to those already specified; they did not.

Sessions 3–4

The third and fourth sessions of the protocol focus on reviewing the sexual safety rules and teaching emotion identification and expression. Little modification of these techniques was required from the original protocol. At the beginning of the third session, the clinician and Graham reviewed the sexual safety rules and the clinician provided additional hypothetical situations. Graham accurately answered questions related to each situation, although some responses took time for him to cognitively process to determine if a rule was being broken. Using crayons and pictures of thermometers, Graham was asked to identify how often he felt angry, sad, scared, happy, and confused, by coloring in the thermometers for each feeling to the accurate level. He reported that happiness was his most common emotion, but that he was sad on occasions when he thinks about the events of the past few months. He denied any regular experiences of anger, fear, or confusion, although he admitted that they do happen on occasion. He did not display any significant problems with emotion identification.

The clinician met with Mr. and Mrs. H. and reviewed Graham's ability to accurately identify his emotions. They agreed that he generally seemed capable of accurately labeling his emotions. In addition, the clinician discussed various steps to implement toward reducing his sexual and other behavioral problems, including eliminating the amount of sexuality displayed in the home and locking doors when in restrooms or engaging in sexual activity. Mr. and Mrs. H. acknowledged already implementing many of these recommendations, but noted that they often forget to lock doors and that monitoring his behaviors is somewhat minimal when he is at home. They committed to improving in both of these areas. In addition, they noted that they had begun correcting his violations of interpersonal boundaries by having him identify the sexual safety rule he was breaking at the time. Mr. H. believed that Graham's poor boundaries were more a result of his lack of impulse control than sexual motivations and believed correcting his behaviors by referencing the rules were helping.

The fourth session provided interesting information. After reviewing the sexual safety rules, Graham completed hypothetical situations with ease. In keeping with the protocol, Graham was asked to specify which of the rules he broke with his sister. He acknowledged breaking rules 1, 3, 4, and 5. He described the incidents that occurred with his sister and specifically identified how each of those rules was broken. The clinician handed Graham crayons and a blank set of the feelings thermometers and asked him to identify how he felt when breaking the sexual safety rules. He colored the "happy thermometer" nearly completely full, and additionally colored low levels for "scared." While processing this response, Graham described feeling happy because of the excitement and pleasure that resulted, particularly at the end. The fear he felt was primarily related to someone walking in and being upset.

Interestingly, when the clinician asked Graham to consider what the feelings of his sister might have been, he was notably confused. He stated that he did not know and was not sure why understanding her emotions was relevant. Graham had previously discussed with the clinician that he is often bullied at school because of his small stature and being an ethnic minority. The clinician asked Graham to identify the emotions he feels when being bullied: sad, scared, and powerless were his answers. However, Graham agreed that the bullies appeared happy. Through discussion of these incidents, Graham was able to recognize that since the bullying created emotional distress for him, it should not occur. Returning to the question about the emotional responses of his sister, Graham was able to generalize the previous discussion about bullying and state that if she displayed emotional distress, then the sexual incidents should not have occurred. With another set of thermometers, he colored what he believed her emotional responses were during the sexual activity: minor levels of sadness and fear. He did not believe the incidents ever appeared to make her happy and it was likely that, if she did have emotional responses, they were negative emotions.

The clinician reviewed the results of the session with Mr. and Mrs. H. They were surprised that Graham was able to identify the emotions of others in the manner that he did. They noted that he did not appear proficient at understanding the emotions of others. The clinician cautioned that the process required significant cognitive effort from Graham and did not appear to be a fluid process. Mr. and Mrs. H. were encouraged to help Graham in the coming week with this process if they noticed opportunities. The clinician reviewed potential warning signs for sexual misbehavior with Mr. and Mrs. H., such as ongoing preoccupation with sexual topics and poor response to redirection. The caregivers had not seen any of the warning signs discussed, but did note that they had increased their monitoring of him. Combined with a greater openness to discuss topics of interest to Graham, Mr. and Mrs. H. believed that their relationship with him was improving and that his behavioral problems were beginning to dissipate. In addition, they noted that approximately 2 weeks had passed since the last incident of Graham attempting to touch Mrs. H's breasts.

Sessions 5–7

These sessions of the Bonner et al., protocol emphasize teaching the client self-control skills and continued review of the sexual safety rules, which Graham had now effectively memorized. In addition, the clinician continued to complete hypothetical situ-

ations to improve Graham's application of the material. For teaching the self-control rules, the clinician decided to use the "Turtle Technique" approach given Graham's below average level of cognitive maturity for a child of his age (see Friedrich, 2007). After reading a brief story about how a turtle solved a problem by relaxing and not acting impulsively, the clinician taught Graham the same steps used by the turtle. These steps included (1) stop and wait, (2) go in your shell and act like a turtle, which is a muscle relaxation technique accomplished through pulling the head into the shoulders combined with controlled breathing, (3) think of possible actions, and evaluate which will achieve desired and undesired outcomes, and (4) pick the action and do it. The clinician discussed how this technique could be applied in the event that Graham is considering breaking a sexual safety rule, or breaking other rules, including times when he identifies himself being angry. After session 5 was spent teaching the "Turtle Technique" to Graham, the following two sessions reinforced and practiced these skills through various games and activities. This last part was a significant departure from the Bonner, et al., protocol, which utilizes games designed for a group setting. Instead, the clinician utilized games and activities more common in individual treatment sessions for teaching impulse control skills, such as processing and reenacting scenarios from the past week of the child's life and playing board games ("Stop, Relax, and Think" game).

Session 5 with the caregivers included teaching them the "Turtle Technique" and a discussion about using it at home when Graham appears angry or frustrated. In addition, the Bonner, et al., protocol prescribes having the caregivers complete a brief checklist asking about their perceptions regarding normative and abnormal sexual behaviors among children. Mr. and Mrs. H's knowledge appeared fairly accurate. The clinician discussed normal sexual development with the caregivers, with the assistance of a pamphlet that discusses various topics related to children's sexual behavior (Johnson, 2010).

In keeping with the treatment protocol, session 6 with Mr. and Mrs. H. focused on teaching effective child behavior management skills. Initial topics focused on teaching the caregivers to be concrete and specific with their instructions and being consistent in their approach to discipline. This included clearly specifying the consequences for breaking rules and delivering those consequences in the manner described. When possible, the caregivers were encouraged to provide choices to Graham that would still result in the desired behavior, so as to avoid giving too many commands and eliciting power struggles. The importance of providing verbal praise for compliance was stressed, and the clinician discussed how ignoring certain behaviors (e.g., whining, frustrating comments) would prompt the reduction of those behaviors. Lastly, the clinician demonstrated an effective time-out procedure for the caregivers and discussed how these different techniques could be implemented with Graham.

Session 7 with Mr. and Mrs. H. focused on applying the behavior management skills learned in session 6 specifically to SBP. Focusing on mastery of parenting skills was particularly important in this case given that St. Amand et al. (2008) identified behavior management skills as the technique most strongly related to improving SBP, and because these skills are strongly related to the treatment of other externalizing problems. To practice these techniques, the clinician provided Mr. and Mrs. H. with various situations where a child has performed a SBP. The clinician used a number of hypothetical situations available in the protocol and developed a number of situations specifically related to the SBPs noted with Graham (e.g., touching aunt's breasts, personal space issues). After Mr. and Mrs. H. developed their hypothesized responses to each situation, the clinician helped them evaluate the possible outcomes of their decisions. While focusing on using the behavior management skills taught during the previous session, neither Mr. nor Mrs. H. remembered to include prompting Graham's use of the "Turtle Technique." The clinician discussed the importance of viewing all of the techniques learned during treatment as an integrated set of skills that complement and enhance the effectiveness of any one technique or another.

Sessions 8–11

These final portions of treatment are designed to provide the child with basic sexual psychoeducation and abuse prevention skills, and continue to reinforce the use of the previously learned skills. In session 8 with Graham, the primary mode of teaching sexual topics was through the use of a book that provides an in-depth discussion of male and female anatomy, reproduction, and sexual maturation (Saltz, 2005). Graham was confused at multiple points and asked various clarifying questions. Most notably, he was confused about the concepts of the sperm and eggs and how the ejaculate was required for reproduction. His questions were legitimate and well structured, and it soon became apparent that he most likely had numerous questions that he never felt comfortable asking previously. When asked by the clinician, he acknowledged that he maintained his fear of asking adults about sexual topics.

During session 8 with the caregivers, the clinician reviewed Graham's responses during session and Mr. and Mrs. H. confirmed that they had not broached any sexual topics with Graham. The clinician reviewed with the caregivers a handout designed to provide information regarding talking with children about sex. The clinician discussed how the caregivers could de-stigmatize the topic for Graham and ways of opening communication on the topic. The clinician reviewed the book used in session with Graham so that they would clearly understand the material of which Graham was now aware. Mr. H. was asked to attempt at least one time in the coming week to initiate a conversation with Graham on a sexual topic (i.e., what kinds of sexual things he hears at school); Mr. H. agreed.

Session 9 began with Graham discussing a recent conversation he had with his uncle regarding sex. He described the

conversation in positive terms, appearing excited and surprised that his uncle willfully listened and discussed the topic with him. Graham was asked to consider what this event means in terms of his ability to discuss topics and rely on his aunt and uncle for support. He was quick to point out that he felt more open with Mr. H. as the conversation unfolded and that he was more likely to go to him in the future with other questions. The remainder of the session was spent reviewing the "Turtle Technique" and his use of the skill in the past few weeks. Graham was able to demonstrate the technique without difficulty.

Session 9 with Mr. and Mrs. H. examined their responses to the conversation and their use of the behavior management skills. They both reported being surprised by Graham's response to discussing the sexual topics. Mr. H. described numerous questions that Graham asked and how he responded. Following the conversation, Mr. H. came to believe that much of Graham's sexual inappropriateness was related to his curiosity and inability to obtain answers about bodily changes, sexual response and reactivity, and why sex was discussed with such frequency at school, in music, and on television. Both caregivers reported having even more empathy and understanding for Graham in the past weeks as a result of these sessions. When asked about the use of the behavior management skills, Mr. and Mrs. H. noted consistent responses and they rarely needed to administer time-out procedures. They discussed a token economy-based sticker chart that they initiated to improve his behaviors, and believed that all of the parenting techniques together were working remarkably well. They reported significant reductions in externalizing behavioral problems since the beginning of treatment, as well as improved personal boundaries, and that he had not attempted to touch his aunt's breasts in over a month. In addition, no concerns were noted regarding any social or behavioral problems at school.

Session 10 focused on teaching Graham and his caregivers abuse prevention techniques. With Graham, this primarily included a discussion of acceptable and unacceptable touches, including which adults are allowed to touch children's sexual parts and under what circumstances. Graham did remarkably well at this activity and stated that it was easy because it only required generalizing the sexual safety rules to other people's behaviors. Graham and the clinician discussed actions that Graham could take to stop sexual abuse if it did occur, and collaboratively developed a list of people he could tell. With the caregivers, similar information was discussed. The clinician emphasized the importance of believing Graham if he ever alleges sexual abuse, the appropriate steps required to initiate a protective services investigation, and how to reinforce the sexual abuse prevention skills in the home.

The clinician broached the topic of safety planning for instances when Mr. and Mrs. H. or Graham might see the adoptive parents or sister, such as at family functions. Mr. and Mrs. H. stated that they would not attend any family function where the adoptive parents were present and would not allow any contact between the adoptive parents and Graham. They declined any further safety planning around this issue as they believed it was irrelevant.

Session 11 reviewed all of the learned skills throughout treatment with Graham and his caregivers. Graham was able to effectively demonstrate the "Turtle Technique," describe each of the sexual safety rules, and acknowledge and discuss his feelings regarding his previous sexual behavior problems. The protocol includes a 10-question final assessment that examines the child's retention of knowledge and skills throughout the protocol. Graham scored a perfect 10 out of 10 on the assessment. He believed that he had made significant progress and was proud of himself. Mr. and Mrs. H. similarly reviewed the progress from their perspective and the techniques they learned and utilized. The clinician provided the opportunity for Mr. and Mrs. H. to ask any final questions they had regarding Graham's sexual or other behavioral problems. They denied having any further questions about those topics, although they noted that he recently began talking more about his feelings toward his adoptive parents, asking questions about his biological parents, and appeared to have an emerging sense of abandonment. Although the protocol includes a 12th session to wrap-up treatment and conduct a post-treatment assessment, the decision was made to continue treatment with Graham, but shift the focus toward these other issues.

Evaluating Outcome and Follow-Up

At the beginning of the 12th session, which represented the conclusion of the Bonner et al. protocol, the original assessment measures were re-administered. As shown in Table 1, Mr. and Mrs. H. noted significant improvements in all areas of clinical concern. Most relevant, they did not report any significant sexual behavior problems on the CSBI and considerable declines on the externalizing behavior scales of the BASC. On the Aggression subscale of the BASC, they noted a drop of two full standard deviations in Graham's score. On Graham's self-report TSCC, he noted considerably less preoccupation with sexual topics than he did when he began treatment. These results suggest that implementation of the Bonner et al. (1999) group treatment protocol with Graham in an individual setting was successful.

Treatment with Graham continued for another 4 months focusing on various issues related to abandonment, communication, and family issues. The court ordered termination of the parental rights of his adoptive parents, and granted full permanent legal custodial rights to Mr. and Mrs. H. Graham was excited about the prospects of remaining with his aunt and uncle and was adjusting well at the point of termination of services. There was no recurrence of any SBP or other externalizing problem. He had wished to apologize to his sister, but his adoptive parents refused to allow any contact with her. Instead, Graham wrote an apology letter, which he saved in his room at home. He wanted to send the letter to his sister; however, the clinician discussed the reasons why this was not possible and Graham understood. At the time of termination, Mr. and Mrs. H. reported enjoying having Graham in their home and they were thankful for the opportunity to parent him.

Discussion

Children with sexual behavior problems come to the attention of mental health professionals with some regularity, but these cases often provoke uncertainty about the appropriate clinical model to use and how to address the common ancillary considerations such as safety concerns. This case study provides a useful illustration of these issues and how they can be successfully addressed within a standard clinical context.

The key complication in responding to children with sexual behavior problems is that the behavior of concern is sexual. Despite a lack of empirical evidence that sexual behavior problems differ from other behavior problems in their development and maintenance (Chaffin et al., 2008; Elkovitch, Latzman, Hansen, & Flood, 2009), it is not uncommon that families, systems, and clinical providers respond differently and with greater alarm to sexual misbehavior than to other typical problem behaviors, such as noncompliance or aggression. Assumptions about what cause the behavior, how it responds to intervention, and the level of risk are often based on misinformation. Sexual behavior is oftentimes considered to operate on unique principles, resulting in more negative and pessimistic beliefs than the data would suggest. In addition, provider as well as caregiver attitudes and beliefs about sexuality may be very influential in the delivery of therapy.

The other key consideration reflected in this case is the context of the sexual behavior problem, especially the quality of the overall parent–child relationship. It is clear in this case that a secure attachment and a warm bond were not present between the child and the adoptive parents. They immediately rejected this child in an extreme way once they learned of the sexual behavior with his sister. They sought to terminate their parental relationship with him. In addition, they were strongly committed to a course of action with this boy that was punitive and developmentally inappropriate; they wanted him prosecuted despite the fact that he is a child from a difficult background and that prosecution could lead to lifelong consequences. This suggests that the parent–child relationship was substandard before the sexual behavior was known and it is possible that this poor relationship may have in part contributed to the onset or persistence of the behavior. Regardless, rejection by parents would be expected to have an ongoing impact on this boy; especially given that it is his second loss of parents.

The clinical model that was applied here is a cognitive-behavioral treatment (CBT) with a specific focus on the sexual behavior and incorporating child-focused and parent-focused components. Theoretically, this is the right treatment match given that the target is a behavior problem and the child is old enough to be an active participant in the treatment process. Interestingly, an individual evidence-based intervention specifically for sexual behavior problems has not yet been evaluated. The selection of the Bonner et al. (1999) model makes sense given that it has the best evidence for long term benefit; a 10-year follow-up finds that the intervention produces rates of sexual misbehavior reoccurrence that are comparable to those for children who never had non-sexual behavior problems (Carpentier et al., 2006). Although the protocol was developed for and tested in a group setting, there is no convincing rationale for why the delivery mode (individual as opposed to group treatment) would be especially relevant to treatment outcomes since the active model components are variations on standard CBT.

In effect, the general content and phases of the group version of the sexual behavior problem CBT were followed in individual sessions. As well, they mirror the typical CBT and parent management training (PMT) approaches that are evidence-based for behavior problems in general: engagement of the child and caregivers; psychoeducation about the problem and the treatment model; establishing reasonable behavioral expectations; teaching the child emotion identification, coping and self-control skills; and ensuring proper household environment and supervision (Chorpita & Daleiden, 2009). Although in this case, certain specific clinical techniques for delivering these standard components were drawn from the Bonner et al., model, they are simply vehicles for accomplishing standard clinical goals of CBT. As is true for evidence-based treatments for externalizing behaviors, the caregivers were actively involved in the therapy, learned all the components, and were instructed to help prompt the child to use new skills.

The important lesson of a case study like this is that it is possible to successfully eliminate a pattern of sexual misbehavior that has been going on for years within a few months using a structured, evidence-informed approach for externalizing behaviors. Although there is not yet a tested version of individual child-parent CBT for sexual behavior problems, there is nothing in the literature to suggest that application of CBT or PMT would not be effective. These models are very well established and work for a range of problem behaviors (Thomas & Zimmer-Gembeck, 2007). Typically, during model delivery one or a few specific problem behaviors are targeted using standard strategies such as establishing expectations, selective attention, and rewards and consequences. When the behavior involves risk or harm to others as with aggressive behavior, it is routine to incorporate strategies designed to protect others from the misbehavior such as enhanced supervision. In other words, all the necessary ingredients are subsumed within the standard model.

The evidence-based practice movement has made many contributions to increasing the array of effective interventions that are now available. Many of the validated models are based on behavioral and cognitive-behavioral theory and principles (Eyberg, Nelson, & Boggs, 2008), and commonly consist of combinations of comparable elements. One downside to the evidence-based practice movement and the emphasis on branded versions is the belief that a study must be published proving that general models work for every variation on problems or case characteristics before it can be applied with confidence. This view tends to obscure the importance of the underlying principles and their accompanying

skills, and leads to over-valuing the specific package. As a result, it can seem as though we have less to offer for the wide variation in clinical presentations than we really do. Although it is important to validate the effectiveness of different interventions for different problems, in many cases, like this one, application of the general evidence-based model is likely to work well.

The current case study was focused on treating a child with interpersonal forms of SBP and clinical trials examining the use of the Bonner et al. (1999) model demonstrate significant results in the treatment of interpersonal SBP (Silovsky, Niec, Bard, & Hecht, 2007). Although studies suggest that this model is likely effective for children with non-interpersonal, self-focused SBP (Bonner et al., 1999), and there is no rationale to believe otherwise, no clinical trials specifically looking at these forms of SBP are available. In addition to the completion of randomized controlled trails examining the efficacy and effectiveness of individual treatment for SBP, studies should examine whether the type, frequency, or intensity of SBP impact treatment outcome. This case study serves as a starting point for this work by demonstrating the potential for an individually-administered treatment program, based on current empirical evidence, to successfully treat a child with SBP.

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