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Implementing Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) With Preteen Children Displaying Problematic Sexual Behavior

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Problematic sexual behavior (PSB) is a fairly common presenting concern among preteen children with histories of trauma. Unfortunately, relatively little information about these concerns are provided in training programs and clinicians often report lacking the skills and confidence to intervene when PSB is present. Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), on the other hand, is a well-known and well-validated intervention for children who experienced maltreatment and trauma. Current evidence-based treatment techniques for PSB are primarily cognitive-behavioral in nature and easily delivered within the standard TF-CBT protocol. This paper reviews the empirical and theoretical premises of evidence-based treatment techniques for PSB and discusses how the clinician can implement them within the context of TF-CBT, while maintaining fidelity to the TF-CBT protocol. Conducting an assessment to determine the appropriateness of this form of treatment is examined as well as recommendations on addressing safety issues that may be identified during assessment.

Problematic sexual behavior (PSB) is a common presenting concern among preteen children with sexual abuse histories (Friedrich et al., 2001; Kendall-Tackett, Williams, & Finkelhor, 1993); however, other forms of maltreatment, such as physical abuse, psychological abuse, and neglect, are also more common among children displaying PSB (Allen, 2017; Merrick, Litrownik, Everson, & Cox, 2008). Oftentimes, the treatment of choice for children experiencing maltreatment is Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006). Randomized controlled trials demonstrate that TF-CBT is effective for reducing posttraumatic stress and internalizing problems secondary to maltreatment, as well as the occurrence of PSB among children (e.g., Cohen, Deblinger, Mannarino, & Steer, 2004). Nonetheless, clinicians often report uncertainty about how to address PSB within the context of TF-CBT, particularly when PSB is the most concerning presenting problem and the initial target of therapeutic intervention. This paper will provide a review of the current state of knowledge on PSB among children, including evidence-based treatment strategies, and provide recommendations for how PSB-focused treatment components can be delivered within standard TF-CBT treatment. For clinical situations where PSB is a presenting concern in the absence of trauma exposure, the reader is referred to Allen, Timmer, and Urquiza (2016), Bonner, Walker, and Berliner (1999), and Friedrich (2007).

Keywords: sexual behavior; child abuse; trauma-focused cognitive-behavioral therapy; child maltreatment

Problematic Sexual Behaviors Among Children

Definition

Children with PSB are a historically understudied population. In an attempt to improve assessment, treatment, research, and public policy for children with PSB, the Association on the Treatment of Sexual Abusers commissioned a task force to study the issue and provide recommendations. The final report (Chaffin et al., 2008) defined children with PSB as "children ages 12 and younger who initiate behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others" (p. 200).

First, this definition recognizes that children typically display various forms of sexually related behaviors throughout development. As such, only developmentally inappropriate behavior is considered problematic. For instance, curiosity about sexual body parts and behavior is fairly normal throughout the childhood years, but the behaviors associated with such curiosity may only be developmentally appropriate when children are younger (e.g., trying to look at people in the shower or bathroom) or older (having questions about romantic/sexual relationships). The reader is referred to Friedrich (2007) for a more detailed discussion of normative sexual development, as well as Johnson (2010) for helpful tables describing developmentally appropriate and inappropriate sexual behavior. Second, the definition recognizes that even

developmentally appropriate behavior may occur with problematic frequency or severity. In these instances, the behavior may be harmful to the person or to others, and require clinical intervention. Finally, certain types of sexual behavior (e.g., attempting to coerce another into sexual acts) are always considered problematic. It also should be noted that use of the term "sexual" does not necessarily imply that the child's behaviors are driven by sexual desires. Motivations for sexual behavior may include self-soothing, curiosity and/or confusion, and attention-seeking (Chaffin et al., 2008). Regardless of whether the sexual behavior is interpersonal or noninterpersonal, it is incumbent upon the clinician to conduct a thorough assessment so as not to label developmentally appropriate sexual behaviors as problematic.

Etiological Theories

A substantial body of evidence suggests that sexual abuse is a significant risk factor for the development of PSB (Friedrich et al., 2001; Putnam, 2003). Perhaps the most well-known theoretical explanation for this connection was provided by Finkelhor and Browne (1985). In their conceptualization of *traumatic sexualization*, sexual abuse is posited as resulting in PSB through two primary avenues. First, drawing on social learning theory, the perpetrator's sexually abusive behavior provides a model for the child and suggests to the child that sexualized behaviors are expected or may achieve desired outcomes. Second, the child may develop significant posttraumatic stress symptoms, such as intrusive thoughts of the abuse, which results in the child performing sexual acts he or she may not otherwise perform. Indeed, research suggests that sexually abused children with PSB are more likely to report posttraumatic stress symptoms than sexually abused children without PSB (Allen, Thorn, & Gully, 2015).

However, a significant proportion of children displaying PSB do not have a sexual abuse history (Allen, 2017; Bonner et al., 1999; Silovsky & Niec, 2002). Other risk factors linked to the occurrence of PSB include family displays of sexuality (Friedrich, Davies, Feher, & Wright, 2003); physical abuse, psychological abuse, and neglect (Merrick et al., 2008); physical discipline methods (Latzman & Latzman, 2015), and various demographic and environmental influences (Elkovitch, Latzman, Hansen, & Flood, 2009), among others. Although social learning theory may explain how family sexuality or exposure to pornography can result in PSB, alternative theoretical positions are necessary to explain the etiological impact of nonsexual risk factors on the development of PSBs.

Research demonstrates that many children with PSB tend to display an increased frequency of other externalizing behaviors, as well as internalizing problems (Allen et al., 2015; Lévesque, Bigras, & Pauzé, 2012). These findings suggest that, in some cases, the development of PSB may be the result of deficits in core social and behavioral skills, such as social skills and appropriate boundaries, impulse control, and emotion regulation (Chaffin, Letourneau, & Silovsky, 2002). Data supports this contention as children with PSB appear more likely to demonstrate below-average social competence (Friedrich et al., 2003) and difficulties with emotion regulation (Lepage, Tourigny, Pauzé, McDuff, & Cyr, 2010). In addition, the experience of various forms of maltreatment may prompt the aberrant development of these capacities (Kim-Spoon, Cicchetti, & Rogosch, 2013; Luke & Banerjee, 2013), resulting in PSB that is indirectly related to trauma exposure.

In summary, three primary theoretical explanations are available to explain the development of PSB in children following a traumatic event: social learning of sexualized behavior; posttraumatic stress-related reactions; and the development of core deficits in social, emotional, and behavioral regulation. These distinct, although not exclusive, etiological explanations provide a foundation for designing and implementing treatment techniques.

Evidence-Based Treatment Components

Relatively few clinical outcome trials have specifically targeted the amelioration of PSB among children. Rather, much of the research evidence is drawn from studies examining treatment of sexually abused children where sexual behaviors were assessed as a secondary outcome, oftentimes with posttraumatic stress being the primary outcome. Many of these studies are evaluations of TF-CBT or similar treatment programs, and most have observed positive effects of these protocols on the display of PSB (Cohen et al., 2004; Cohen & Mannarino, 1996; Cohen & Mannarino, 1998; Deblinger et al., 2001; Stauffer & Deblinger, 1996).

St. Amand, Bard, and Silovsky (2008) conducted a meta-analysis of 11 clinical trials that examined PSB as an outcome variable. They noted that treatment programs, on average, demonstrated a medium pre-post effect size (.46). In addition, the authors coded the treatment elements of each protocol in the meta-analysis to determine if specific techniques might result in greater therapeutic benefit. Across studies, five treatment components were significantly associated with positive treatment outcome for PSB. The most influential technique was teaching the parent to implement child behavior management skills in the home. In addition, benefit was noted for establishing rules about sexual behavior, including teaching parents how to distinguish normative from problematic sexual behavior; providing education to parents about communicating with their children about sexual topics and building the parent-child relationship; and parent-focused abuse prevention skills, such as emphasizing the caregiver's role in protecting the child and being vigilant about who interacts with the

child. The only child-focused treatment technique found to predict better outcomes was teaching the child impulse control and problem-solving skills. Based on these results, the researchers concluded that treatment for children with PSB should focus heavily on skill development with the caregivers.

Trauma-Focused CBT

TF-CBT is a structured, components-based treatment protocol for children who experienced traumatic events and subsequently developed significant emotional and/or behavioral problems (Cohen, Mannarino, & Deblinger, 2006). TF-CBT sessions are typically divided into two parts, with the first portion of the session involving individual sessions with the child and the second portion involving individual sessions with the caregiver(s). The time with caregivers is typically spent addressing topics similar to those of the child sessions, as well as focusing on the development of parenting skills. In addition, conjoint parent-child sessions frequently occur. The initial phase of TF-CBT focuses on skill-building and later sessions focus on processing the child's traumatic memories through the development of a trauma narrative. The traumatic event is acknowledged and discussed beginning at the first contact with the child and caregiver, and continued gradual exposure is integrated into each component of TF-CBT (see Deblinger, Cohen, & Mannarino, 2012, for a discussion of the centrality of gradual exposure in TF-CBT). The components of TF-CBT, summarized by the acronym PRACTICE, are shown in Table 1. For a more thorough review of TF-CBT research, the reader is referred to Allen and Hoskowitz (2014).

The conceptual underpinnings of TF-CBT are congruent with the three etiological explanations of PSB discussed

Table 1
TF-CBT Components and PSB-Specific Techniques

	TF-CBT Component	Potential PSB-Specific Techniques
P	Psychoeducation (information about trauma and trauma reactions)	• Provide sexual psychoeducation to the child, including anatomical names of body parts and the process of reproduction. • Provide information to the caregivers regarding normative and problematic sexual behaviors in children • Demonstrate for caregivers the connection between the child's posttraumatic stress symptoms and his/her display of PSB.
P	Parenting skills (behavior management skills)	• Establish sexual behavior rules with the caregivers and describe these rules for the child. • Develop a behavior management plan that specifies parental responses to PSB. • Develop a safety plan for use in the home and community. • Increase monitoring of the child to reduce the opportunity for SBPs to occur. • Develop the caregiver's ability to effectively communicate with the child, particularly around topics related to sex and sexual behavior.
R	Relaxation skills (Managing physiological reactions to trauma)	• Link the use of learned relaxation skills to times when the child is likely to engage in sexual behaviors
A	Affect modulation skills (managing affective responses to trauma)	• Teach the child and caregiver impulse control skills, including problem-solving skills. • Encourage and reinforce use of the skills outside of treatment sessions.
C	Cognitive coping skills (connections between thoughts, feelings, behaviors)	• Provide examples of hypothetical sexually-based situations and process how thoughts and feelings impact behaviors.
T	Trauma narrative and processing (correcting cognitive distortions related to trauma)	• Evaluate and process cognitions of shame, guilt, and self-blame, related to PSB. • Process other potential maladaptive cognitions related to PSB, if observed.
I	In vivo mastery of trauma reminders (overcoming generalized fear related to trauma)	• Develop a plan to re-establish trust in the child's ability to not perform PSB. May include building up to unsupervised time with other children.
C	Conjoint child-parent sessions (variety of conjoint child-parent activities)	• May be used throughout the protocol to increase communication related to sexual topics, discuss behavior management plans and sexual behavior rules, and practice impulse control and problem-solving skills.
E	Enhancing safety and future development (safety skills and planning for the future)	• Emphasize the caregiver's role in preventing sexual abuse, including being vigilant of the people who interact with the child.

above. First, TF-CBT was designed specifically to ameliorate posttraumatic stress symptoms, and meta-analyses of clinical trials demonstrate that TF-CBT is highly effective at achieving this goal (Allen, Henderson, Johnson, Gharagozloo, & Oseni, 2012; Cary & McMillen, 2012). As a result, posttraumatic stress-related PSB should be significantly reduced through TF-CBT, a hypothesis validated by the St. Amand et al. (2008) meta-analysis. Second, TF-CBT recognizes the importance of involving caregivers in treatment and of teaching caregivers behavioral child management skills. Using social learning and operant behavioral models, a TF-CBT clinician can address environmental factors and behavioral contingencies that may be maintaining the PSB. Finally, TF-CBT emphasizes the development of adequate coping skills to improve the child's ability to regulate emotions and improve behavior.

The treatment of PSB within the TF-CBT protocol has received relatively little attention. The treatment manual (Cohen et al., 2006) makes a brief reference that PSB may be related to posttraumatic stress and sexual abuse, but does not discuss unique treatment considerations for these concerns. In addition, treatment of PSB is rarely discussed in depth during standard TF-CBT training programs. Fortunately, the five PSB-focused treatment techniques identified by St. Amand et al. (2008) can be seen in many ways as special cases or applications of techniques already included in the standard TF-CBT protocol. Indeed, 5 of the 11 studies reviewed examined TF-CBT. Importantly, TF-CBT's component-based approach lends itself to the assimilation of a more PSB-focused delivery of the designated treatment techniques.

Assessment: Is TF-CBT Appropriate?

TF-CBT is designed to focus specifically on addressing sequalae of trauma, and is not meant as a panacea for all children presenting for treatment. As such, it is important to determine whether the child experienced a traumatic event, and if the child is experiencing symptomatology connected to the experience of the trauma. PSB-focused treatment techniques can be implemented with various other treatment protocols if a trauma-focused intervention is not indicated. Although a thorough discussion of the various assessment issues involved is beyond the scope of this paper (the reader is referred to Chaffin et al., 2008, and Friedrich, 2007), specific issues relevant to determining whether TF-CBT is appropriate for treating PSB are discussed below.

Assessment of Trauma and Trauma-Related Symptoms

A foundational technique of assessment is the clinical interview. Clinicians are encouraged to directly ask the child and caregiver about previous traumatic experiences and the timing of the onset of the problematic behaviors or symptoms in relation to experiencing the traumatic event. Directly discussing and obtaining a trauma history during the initial assessment serves multiple functions. First, it demonstrates to the child and caregiver that sessions will directly discuss and process traumatic experiences. In this way, the gradual exposure component of TF-CBT begins from the first contact with the child. Second, it will allow the clinician to more precisely focus the techniques of the intervention on the most influential traumas. It is not uncommon for a child to begin treatment services with a specific traumatic event identified as the source of concern (e.g., sexual abuse); however, upon conducting a thorough trauma assessment, it is learned that the child's trauma history is complex and the most troubling event for the child may not be the index trauma that prompted the referral. Lastly, it is important to determine whether the problematic behaviors are the result of identified traumatic events. Preexisting emotional and behavioral problems may be exacerbated by the stress of a traumatic event, but the most appropriate treatment approach in these cases may not be a trauma-focused intervention.

Clinicians are encouraged to utilize self-report and caregiver-report assessment instruments. These measures provide a more objective assessment of the level of symptoms present and provide a baseline for tracking progress throughout treatment. The Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005) is a well-validated caregiver-report measure for children ages 3 to 12 that provides a broadband assessment of various trauma-related symptoms, including posttraumatic stress, dissociation, and depression. Notably, the TSCYC includes a scale directly assessing sexual concerns. The companion child-report measure, the Trauma Symptom Checklist for Children (TSCC; Briere, 1996), is appropriate for children ages 8 to 16 and assesses symptom categories similar to the TSCYC. Appropriate measures that focus specifically on post-traumatic stress, and require less time and financial resources, include the UCLA PTSD Reaction Index (Pynoos & Steinberg, 2014) and the Child PTSD Symptom Scale (Foa, Johnson, Feeny, & Treadwell, 2001). If no trauma history is reported, or the child does not display significant post-trauma symptoms, TF-CBT is not the most appropriate treatment approach. In such cases, other evidence-based treatments should be considered for identified problems, including PSB (e.g., Allen et al., 2016; Bonner et al., 1999; Friedrich, 2007).

Assessment of Sexual Behavior Problems

If a trauma history is present and TF-CBT appears appropriate for a child displaying PSB, an effective assessment of the PSB is required prior to beginning treatment. During the clinical interview the clinician

should collect information specifically related to the onset, type, and frequency of the PSB:

1. *Did the PSB begin before or after the identified traumatic event(s), or was it exacerbated by the trauma?* The answer to this question, and relevant follow-up questions, can help determine whether the PSB is a possible posttraumatic stress symptom. In addition, responses to these questions can alert the clinician to the presence of non-trauma-related factors maintaining the PSB, such as familial displays of sexuality, access to pornography, poor parental monitoring, and other factors. Addressing these issues should be a focus of treatment.
2. *What specific types of PSB are present?* It is important from a treatment and safety perspective to identify the severity of the PSB. The clinician should ask whether the PSB has involved other children (i.e., interpersonal), if personal safety concerns are present (e.g., the child inserts objects into the vagina or rectum), and the diversity of problems present. Use of the Child Sexual Behavior Inventory (CSBI; Friedrich, 1997) can assist in this process. The CSBI is a caregiver-report questionnaire for children between the ages of 2 and 12 years. It asks caregivers to identify the frequency of 38 different sexual behaviors, including interpersonal, self-stimulating, and exhibitionistic behaviors, among others. Administering the CSBI and following up on endorsed items can facilitate the assessment process.
3. *How frequently does the identified PSB occur, and what is the caregivers' response?* It is not uncommon for caregivers to present for treatment with significant concerns about sexualized behavior, even if the behavior occurred a single time. Knowing the frequency of the PSB, the caregivers' reaction and response to the behavior, and if the PSB persisted following the caregivers' attempts to control its occurrence, are important considerations during assessment. For instance, more frequent behaviors and behaviors that do not respond to parental discipline or redirection may indicate impulsivity and/or posttraumatic stress reactions that are difficult for the child to control. Conversely, significant attention from caregivers or others may serve to positively reinforce and maintain the PSB.

Throughout the assessment, clinicians should be acutely aware of any issues that convey safety concerns. Friedrich (2007) provides a safety checklist that may be useful for identifying various risk factors for the commission of PSB. When safety concerns are identified, appropriate measures should be implemented. For instance, caregivers should be encouraged to increase monitoring of the child when concerns about interpersonal sexual behaviors or potentially harmful self-focused sexual behaviors are present. Specific parenting skills focused on increasing safety in the home are discussed below.

Delivering Evidence-Based PSB Treatment Components Within TF-CBT

Numerous opportunities exist to deliver evidence-based PSB treatment components within the standard TF-CBT protocol. Recommendations of ways to deliver various techniques are summarized in Table 1. The sections below discuss PSB interventions that may be implemented during selected components of TF-CBT.

Psychoeducation

Few emotional and behavioral problems concern caregivers as much as the display of sexualized behaviors. Effective psychoeducation can allay many of these concerns. In instances where the behavior is within normal limits, discussing normal sexual development and allowing parents to ask questions can be particularly helpful. Excellent resources are available to facilitate this process (National Center on the Sexual Behavior of Youth [www.ncsby.org]; National Child Traumatic Stress Network, 2009a, 2009b). If the PSB appears primarily related to posttraumatic stress reactions, the clinician should discuss these behaviors within the context of a larger discussion regarding posttraumatic stress symptoms. In addition, the clinician can address other identified risk factors at this point, such as familial sexuality or access to media depicting sexual acts, by discussing how these influences may be influencing the sexual behaviors.

Treatment with the child will involve a direct discussion of sexual topics; however, many times, caregivers express concerns about discussing sexual topics with children. It is typically helpful to acknowledge the caregivers' concern, but stress that the child is already displaying sexual interest or knowledge and/or was already exposed to information on sexual topics, and that the child's current perspectives and behavior is maladaptive. Thus, providing more adaptive information and clearly specifying limits of sexual behavior is necessary. A discussion of the importance of discussing sexual topics should be included when providing a rationale for TF-CBT treatment.

Psychoeducation with the child in regard to sexual topics is important for several reasons. First, it sets an expectation from the beginning of treatment that sexual issues will be a topic of treatment sessions. Second, it starts the process of desensitizing the child to the often embarrassing topic of sex, and in cases of sexual abuse may serve to begin the trauma-focused gradual exposure process. Third, sexual psychoeducation can provide the child with basic knowledge and vocabulary regarding sexual topics that can expedite the treatment process. Sexual psychoeducation

with the child might include teaching the child "doctor's names" for sexual body parts, discussing behaviors that constitute "sexual behavior," and describing the reproduction process. Numerous books are available that can aid in the psychoeducation process with the child (e.g., Brown & Brown, 1997; Mayle, 1977; Saltz, 2005), and the clinician is encouraged to allow the child the opportunity to ask questions. The caregivers should be aware of the information discussed with the child, and including the caregiver in the session may be helpful for increasing communication between the caregiver and child regarding sexual topics.

Parenting Skills

As discussed earlier, the primary evidence-based technique for treating PSB is developing effective child behavior management skills among the caregivers. Indeed, developing these skills should be a primary goal in the treatment of PSB and occur as early in the treatment process as possible. Standard TF-CBT places the teaching of parenting skills at the beginning of the protocol and emphasizes teaching caregivers to manage externalizing behavior problems, such as aggression and oppositional behavior, using positive reinforcement (e.g., praise, token economy), social modeling, time-out sequences, and active ignoring/selective attention for undesired behavior, among other techniques (Cohen, Berliner, & Mannarino, 2010). These same skills are applicable to the management of PSB; however, specific adaptations of these techniques may be warranted.

First, it is typically necessary to clearly explicate sexual behavior rules for the child. While rules are typically well specified and often discussed related to aggression (e.g., "no hitting") and other externalizing problems (e.g., "Don't take other people's things"), caregivers often assume that children are aware of sexual rules and a clear description of acceptable and nonacceptable behaviors is never provided. It is vital that sexual behavior rules be clearly stated for the child as it allows the caregivers to convey expectations and permits the defining of clear consequences when the rules are broken.

Sexual behavior rules need to be concrete and explicitly explained to the child, and the clinician should discuss the development of these rules with the caregivers. Bonner et al. (1999) provide some useful examples: (a) It is not OK to touch other people's private parts, (b) It is not OK for other people to touch your private parts, and (c) It is not OK for you to show other people your private parts. Depending on the child's unique PSB, other rules might be added, such as: (a) keeping personal space between me and others, (b) letting my parents know if someone does or asks to do something sexual with me, and (c) not saying sexual words around other people (Friedrich, 2007). One particular rule that should be discussed with caregivers is the acceptability of the child touching his or her own sexual parts when in private (e.g., exploration, masturbation). Depending on cultural and religious beliefs, some parents may object to sanctioning self-touching, even if done in private. It may be advantageous for the clinician to revisit information on normative sexual behavior in children, the impact of trauma, and discuss the importance of describing sexual behaviors as a private activity as opposed to a moral failing of the child. Even if the caregivers believe the child's sexual behavior is immoral, it is most likely counterproductive to label it in these terms for a child who has difficulty controlling the behavior.

Once the sexual behavior rules are clearly defined in session with the caregivers, the next step is to develop a behavior management plan. The consequences of breaking the sexual behavior rules should be concretely stated for the child, and make use of standard behavioral interventions. For instance, exposing sexual parts to others may prompt an automatic time-out, or the child may receive stickers, praise, or other rewards for maintaining appropriate personal space. As with the treatment of other externalizing problems, consistency in the application of the behavior management plan is vital. All designated caregivers should be aware of the sexual behavior rules, and understand and implement the behavior management plan consistently. For a more detailed discussion of managing externalizing behavior problems in the context of TF-CBT, the reader is referred to Cohen et al. (2010).

Once the sexual behavior rules and behavior management plan are clearly specified, a conjoint parent-child session should be employed to explain these issues to the child. It is important that this session proceed as a conversation with the child where his or her questions and concerns can be addressed. The clinician and caregivers should go through each of the sexual behavior rules, discuss examples of each rule applicable to the child, and explain how the parent will respond when the rules are broken. The child's input on the form of the rules and consequences should be considered, and any mutually agreed upon changes should be integrated into the behavior management plan. The clinician should consider discussing these rules with the child in subsequent sessions to ensure understanding, and discuss and troubleshoot with the caregivers any difficulties implementing the behavior management plan throughout treatment.

Safety issues may be present when PSB is a concern. As mentioned before, one of the most effective safety measures is to increase monitoring of the child. This might include not allowing the child to be alone in a room with siblings, or require the child to leave his or her bedroom door open when playing alone. Some forms of PSB may occur only when the threat of discovery is low. Therefore, the goal of increased monitoring is to remove the opportunity to perform a PSB. Caregivers should also

consider having discussions with siblings regarding the sexual behavior rules and actions to take if the child is concerned the rules are being broken. Other safety measures may be appropriate given the unique considerations of the case. The reader is referred to Friedrich (2007) for a more in-depth discussion of safety planning.

Perhaps one of the most effective safety measures is the ability of the caregiver to effectively communicate with the child. The clinician should spend time with the caregiver increasing his or her ability to effectively discuss sexual topics with the child. Many forms of PSB may be the result of child curiosity or confusion. Providing a supportive and open atmosphere related to sexual topics may prompt the child to verbalize their sexual interests and questions rather than acting on them. In addition, building the parent-child relationship and communication may improve the sense of trust, support, and acceptance, and result in better outcomes when the parent delivers consequences dictated by the behavior management plan. Conjoint parent-child sessions focused on discussing sexual psychoeducation topics may be particularly helpful in achieving this goal.

Affect Modulation Skills

The only child-focused techniques identified by St. Amand et al. (2008) as significantly associated with positive outcomes for PSB were teaching the child impulse control and problem-solving skills. These skills often integrate relaxation skills such as controlled breathing and muscle relaxation, which are typically taught to children during the *relaxation skills* component of TF-CBT. Teaching impulse control and problem-solving skills during the *affect modulation skills* module allows the clinician to build on the previously learned relaxation skills while incorporating the feelings identification skills of this module.

Specifically, as the clinician is teaching the child feelings identification and linking these feelings to different situations, he or she can include situations where the child engages in PSB. Identifying the pre-behavior feelings can help the child ascertain when to implement the impulse control and problem-solving skills. Mindfulness skills that teach the child to identify sensations associated with impulses related to the commission of PSB, and that such impulses can be controlled, may be particularly helpful. In addition, other affective modulation skills taught to the child during this module (e.g., positive imagery) can be directly linked to preventing the occurrence of PSB.

Teaching the child impulse control and problem-solving skills is typically a multistep process. Numerous suggestions are available for implementing these skills, and the reader is referred to Lochman, Wells, and Lenhart's (2008) Coping Power Program, and Friedrich's (2007) description of the "turtle technique." Generally, these techniques involve the implementation of relaxation skills to initially prevent an impulsive response when the situation or feelings identified with the PSB occur. The child is taught to then identify options for his or her behavior, evaluate the likely consequences of the different options, and then pick an option and perform the behavior. It is often the case that this process must be rehearsed multiple times in session for the child to demonstrate mastery. As with other TF-CBT skills, it is advantageous for the child to teach these skills to the caregiver, and for the caregiver to practice the skills with the child on a regular basis at home. Positive reinforcement for the appropriate use of the skills outside of session is encouraged. For a demonstration of the implementation of PSB-focused psychoeducation, parenting skills, and affect modulation techniques in a case study format, the reader is referred to Allen and Berliner (2015).

Trauma Narrative and Processing

It is not uncommon for children with PSB to develop significant maladaptive cognitions around their PSB that results in guilt, shame, and other unhelpful feelings. Clinicians are instructed to elicit the child's thoughts at different points throughout the narrative construction process. Maladaptive thoughts related to PSB often present themselves during the construction of the trauma narrative (e.g., "I'm as bad as my uncle because I touched my sister just like he touched me"). If the child does not talk about his or her PSB during the narrative construction, it may be helpful for the clinician to broach the topic by including a chapter in the trauma narrative specifically related to the child's PSB.

During the discussion of the PSB, the clinician should reintroduce information from the psychoeducation component to increase the child's understanding of the material as it relates to his or her own behavior. With this information as a background, the cognitive restructuring process can proceed much as it does for other maladaptive cognitions related to the trauma. For instance, the child might be asked to determine if he or she would have performed the PSB if the abuse or trauma had never occurred. Alternatively, the child might be asked to consider what he or she might say to another child in a similar situation. The purpose of this discussion is for the child to consider the PSB as a result of the trauma or trouble coping with upsetting feelings, as opposed to a personal failing. The clinician can emphasize the child's reduced posttraumatic stress and subsequent sexualized behaviors and/or improved coping skills to increase the child's confidence in his or her ability to no longer perform the PSB.

If the PSB predated the trauma and TF-CBT was deemed the most appropriate treatment approach, the

clinician's attempts to address the child's maladaptive thoughts related to the PSB should be modified accordingly. Specifically, the clinician should not view the trauma as an etiological factor (although possibly an exacerbating factor) or encourage the child to process thoughts in such a way. Rather, cognitive restructuring may focus much more on the meaning assigned to the behaviors or bolster the child's confidence in his or her ability to refrain from such behavior in the future. The manner in which this proceeds is dictated by the nature of the maladaptive thoughts, but the clinician should not attempt to link the PSB to the trauma if the trauma does not appear to be etiologically related.

In Vivo Mastery of Trauma Reminders

TF-CBT emphasizes the child and caregiver demonstrating mastery over physical reminders of the traumatic event. PSB creates similar fears to real-world situations, albeit in a different manner. Predominantly, caregivers express concerns about the child being alone with, or even around, other children. Assuming amelioration of posttraumatic stress and improved coping skills, it may be appropriate to consider rebuilding trust in the child's ability to not perform PSB. As with any *in vivo* exercises, a well-defined plan should be constructed that will increase the possibility of success. The ultimate goal is for the child and caregiver to be comfortable with the child playing with other children with no more supervision than is typical for the child's age. The starting point for this *in vivo* exercise and the individual steps in the process will depend a great deal on the level of separation from other children and caregiver supervision the child is experiencing at the beginning of the process. For a more defined process of reuniting families and siblings impacted by intrafamilial sexual abuse, the reader is encouraged to consult Lipovsky, Swenson, Ralston, and Saunders (1998).

Caregivers often display hesitation and fear at this point of the process. It is usually helpful for the clinician to remind the caregiver that children with PSB who receive appropriate treatment, which occurred through TF-CBT, are at no greater risk for committing future sexual offenses than children who do not display PSB (Carpentier, Silovsky, & Chaffin, 2006). In addition, the clinician should emphasize the importance of returning the child to a normal developmental trajectory, including peer relationships. It may be helpful to emphasize the period of time since the last known PSB and refresh the caregiver(s) on the learned skills. As mentioned previously, it will also be important to teach any siblings in the home appropriate safety skills prior to beginning this process. It should be noted that this process is not meant to replace the *in vivo* exposure to trauma reminders that is a part of the standard TF-CBT protocol; rather, the process discussed here is meant to supplement that process. Depending on the child's symptomatology and progress, these *in vivo* exercises related to increasing trust of the child around others may need to occur after the successful completion of the *in vivo* exposure plan related to trauma reminders.

Enhancing Safety and Future Development

It is important for the clinician to teach the child and caregiver abuse prevention skills in order to minimize the risk of future trauma exposure. However, this module is already included in standard TF-CBT and little modification is required. Caregivers should understand the importance of believing any future reports of abuse or trauma from the child and the appropriate steps to take to protect the child. It may be useful to discuss substitute caregivers (i.e., babysitters) who are and are not appropriate, including caregivers who might be sensitive to the child's needs for emotional and behavioral support. In addition, assertiveness training for the child may be indicated as well as teaching the child the steps to take in the event of future abuse or trauma exposure. The clinician might have the child develop a list of trusted adults he or she can talk to when feeling scared or if someone has acted or requested the child to act inappropriately. Other abuse prevention recommendations are available in Cohen et al. (2006).

Summary

Although limited, the extant research on PSB among children provides useful treatment recommendations. Specifically, parent-focused techniques, such as behavioral child management training, psychoeducation, abuse prevention skills, and development of sexual behavior rules, are indicated as central treatment components. In addition, teaching child impulse control and problem-solving skills may be helpful. Each of these identified techniques is primarily drawn from a cognitive-behavioral theoretical background. As such, delivering PSB-focused treatment techniques within defined and tested CBT protocols is a logical and practical approach to treating PSB that co-occurs with other presenting concerns. Given that PSB commonly co-occurs with post-trauma sequelae, it is important for practicing clinicians to understand how PSB can be treated while maintaining fidelity to a trauma-focused CBT protocol, such as TF-CBT. It is hoped that this paper will provide practicing clinicians with direction and confidence when treating children presenting with co-occurring PSB and post-trauma sequelae.

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