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

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A B S T R A C T

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

1. Introduction

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

It is important to highlight that children with PSB differ substantially from adolescents and adults with sexual behavior concerns (Chaffin et al., 2008; Chaffin & Bonner, 1998; Chaffin, Letourneau, & Silovsky, 2002). Although sexual body parts are involved in the behavior, for young children the motivations, intentions, culpability, context, and responsivity to caregiver, community, and clinical interventions are quite distinct from adolescents and adults (Bonner, Silovsky, Widdifield Jr., Shawler, & Bard, 2017; Chaffin et al., 2002). Friedrich (2007) reported that sexual behavior exhibited by young children does not focus on sexual arousal, "but a combination of exploration, happenstance, impulsivity, and curiosity (p. 42)." Furthermore, the early emergence of PSB does not appear to lead to a trajectory of sexual offending behavior into adolescence and adulthood (Carpentier, Silovsky, & Chaffin, 2006; Chaffin et al., 2002).

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

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

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

2. Treatment of preschoolers with Problematic Sexual Behavior

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

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

Many preschool aged children with PSB do not present with a known history of sexual abuse or PTSD. As such, a specific intervention that directly targeted PSB for young children was developed (Silovsky et al., 2007; Silovsky & Niec, 2002). Cognitive Behavioral Therapy for Preschoolers with Problematic Sexual Behavior and their Families (PSB-CBT-P) is a closed-ended, group therapy model consisting of 12 sessions that focus on providing a developmentally sensitive treatment model designed for young children's cognitive, emotional, and behavioral capacities (Silovsky et al., 2007; Silovsky, Niec, Widdifield, Campbell, & Funderburk, 2015). The therapy model is rooted in behavioral and cognitive-behavioral principles. The child and caregiver(s) are actively involved. The caregiver component of treatment addresses psychoeducation on sexual development and PSB, parenting skills to supervise, monitor, prevent, and respond to PSB, general BPT skills, and embeds caregiver support through the group processes. The children's group is focused on learning healthy boundaries, rules about behavior, coping skills, self-control skills, and social skills. In a multi-subject (N = 85), multiple baseline (wait and treatment periods) study, significant reductions in PSB were found for treatment above and beyond the wait period (Silovsky et al., 2007).

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

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

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

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

present with primary concerns of posttraumatic stress symptoms and minimal PSB may be best served in TF-CBT; children who present with elevated disruptive behaviors and minimal PSB may be best served in standard PCIT; children who present with PSB and minimal levels of behavior problems and/or posttraumatic stress symptoms may be best served in PSB-CBT-P; and children who present with elevated PSB and elevated disruptive behaviors may be best served by the model outlined in this article. Additional research is needed in each scenario to advance the field.

3. Parent-Child Interaction Therapy

PCIT is an evidence-based behavioral treatment for young children ages 2 to 7 with disruptive behavior problems (California Evidence-Based Clearinghouse, 2017; Eyberg & Funderburk, 2011; Funderburk & Eyberg, 2011). PCIT was developed from Hanf's (1969) two-stage treatment model based on attachment concepts and social learning theory. The treatment consists of a relationship enhancement phase (i.e., Child-Directed Interaction, CDI) and a caregiver limit-setting phase (i.e., Parent-Directed Interaction, PDI) that together are designed to reduce a multitude of child disruptive behaviors. The two phases of treatment parallel the model of parenting that Baumrind (2013) described as Authoritative Parenting, which provides a balance of warm nurturance and clear limit-setting.

Within CDI, caregivers are taught to follow the child's lead in play; provide behavior specific praise (i.e., labeled praise) to reinforce appropriate child behavior; repeat back child vocalizations in a non-questioning, affirming tone (i.e., reflection) to demonstrate that a caregiver is actively listening; imitate appropriate child behaviors to demonstrate approval and scaffolding of ideas to support positive interaction; to narrate child play (i.e., behavior description) to provide attention appropriate child behavior; and to enjoy the shared time with their child as the caregiver-child relationship is strengthened. Caregivers are expected to practice the CDI skills outside of session in the home environment during a 5-minute daily play period, called "special time." During this time, caregivers are instructed to pick out selected play toys, let the child choose the toy, for the caregivers to follow the child's lead by not asking any questions, giving instructions (i.e., commands), or criticizing the child. In the PDI phase, caregivers are taught how to provide specific and effective instructions (i.e., direct commands) in order to increase the odds of child compliance. In addition, caregivers learn a systematic discipline procedure that can be implemented in a calm, clear, and consistent way. PCIT focuses not on specific behavior problems but on changing the pattern of the caregiver-child interactions in which these problems occur (Eyberg, 2005). The caregiver and child are actively engaged with one another in session while the clinician provides live coaching to guide the caregiver toward mastery of defined skills in CDI and PDI.

Treatment providers in PCIT collect ongoing data nearly every session, and that data dictates the goals for sessions as well as the progression through treatment (Eyberg & Funderburk, 2011). Progression involves the caregiver mastering operationally defined skills (e.g., labeled praise, behavior description, reflection; direct command) during the special time practice with his or her child. Treatment utilizes planned gradual expansion and generalization of skills as the caregiver masters targeted skills and the child demonstrates improved behavioral responses based on parental contingencies. For example, the caregiver must master the relationship enhancing skills of CDI before moving on to PDI, where disruptive behaviors that have been addressed with selective attention during CDI will be addressed in a more direct fashion.

PCIT has gathered widespread support for adapted treatment of several populations (Wilsie, Campbell, Chaffin, & Funderburk, 2017). Additionally, many have adapted PCIT for particular diagnostic groups, such as Masse, McNeil, Wagner, and Chorney (2007) conceptualization of PCIT for children with ASD, the addition of motivational enhancement techniques for high-risk caregivers who were court mandated to treatment (Chaffin et al., 2004; Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011), and the addition of elements to address for child social anxiety (Comer et al., 2012). PCIT has proven reliably effective across a number of contexts and populations including cultural adaptations in which all core features of treatment are retained (Abrahamse, Junger, van Wouwe, Boer, & Lindauer, 2016; Leung, Tsang, Sin, & Choi, 2014; Matos, Torres, Santiago, Jurado, & Rodríguez, 2006; McCabe & Yeh, 2009). The treatment has proven effective with a variety of family compositions, including caregivers who have previously engaged in physical abuse of their children (Chaffin et al., 2004) and foster and/or adoptive families (Timmer, Urquiza, & Zebell, 2006). Taken together, PCIT has demonstrated strong utility for a range of early childhood concerns and shows promise for positive outcomes for young children with PSB.

4. Rationale for adapted PCIT for preschoolers with PSB

We propose that PCIT be augmented with specific treatment elements that have demonstrated reduction of PSB to best serve young children with co-occurring disruptive behavior disorders and significant levels of PSB. This proposal is based upon the available evidence and expert recommendations (Allen et al., 2016; Silovsky et al., 2007; St. Amand et al., 2008). Eyberg (2005) defines treatment adaptation as a change "in the structure or content of an established treatment" (p. 200) which may be "made when aspects of the standard treatment are not feasible or sufficient in the new population" (p. 200). We conceptualize that current existing treatments in isolation are not feasible or sufficient for children with co-occurring clinically elevated disruptive behavior problems and clinically elevated PSB. Therefore, the proposed treatment adaptation addresses what treatment will work best, for whom, and under what conditions.

In terms of areas for augmentation, the meta-analysis on treatment for PSB provides guidance (St. Amand et al., 2008). BPT programs lack psychoeducation regarding young children with PSB, supervision and monitoring strategies to prevent PSB, plans to establish rules regarding private parts, developmentally appropriate sexual education, or abuse prevention, the modules shown to be associated with reductions in PSB. Targeting both PSB and general disruptive behavior problems is essential as disruptive behaviors are unlikely to dissipate without intervention (Boggs et al., 2004). Therefore, augmenting existing evidence-based BPT programs, such as PCIT, to address PSB appears to be a logical modification for preschoolers who present with co-occurring disruptive behavior disorder and PSB.

As with other disruptive behaviors, the origins and maintenance of PSB is impacted by factors in the environment that serve as antecedents, responses, and consequences. Although caregiving practices are rarely the sole cause of the PSB, caregivers of young children can be effectively taught through BPT to change the environmental factors that are maintaining the behavior problems. A meta-analysis of BPT (Kaminski et al., 2008) found increasing caregiver-child interactions, teaching caregivers consistency and appropriate use of timeout, and requiring practice of skills yielded large effect sizes within BPT programs. As noted earlier, BPT was found to be the most significant predictor of reducing PSB in the most recent meta-analysis on treatment of PSB (St. Amand et al., 2008). Further, PCIT and PSB-CBT-P share many overarching treatment components (Fig. 1).

Ethical considerations also necessitate adaptation of PCIT. Children with PSB are a unique at-risk population, as there are often significant safety concerns for the child with PSB as well as other children. Caregivers require support around supervision and safety planning to reduce the immediate risk of PSB with other children. PCIT traditionally delays teaching a caregiver to directly address concerning behaviors until the PDI phase of treatment, but such delay may create safety concerns and threaten current home and school placements. In light of the available research and ethical responsibilities, we propose that an adaptation of PCIT is warranted for this subset of children.

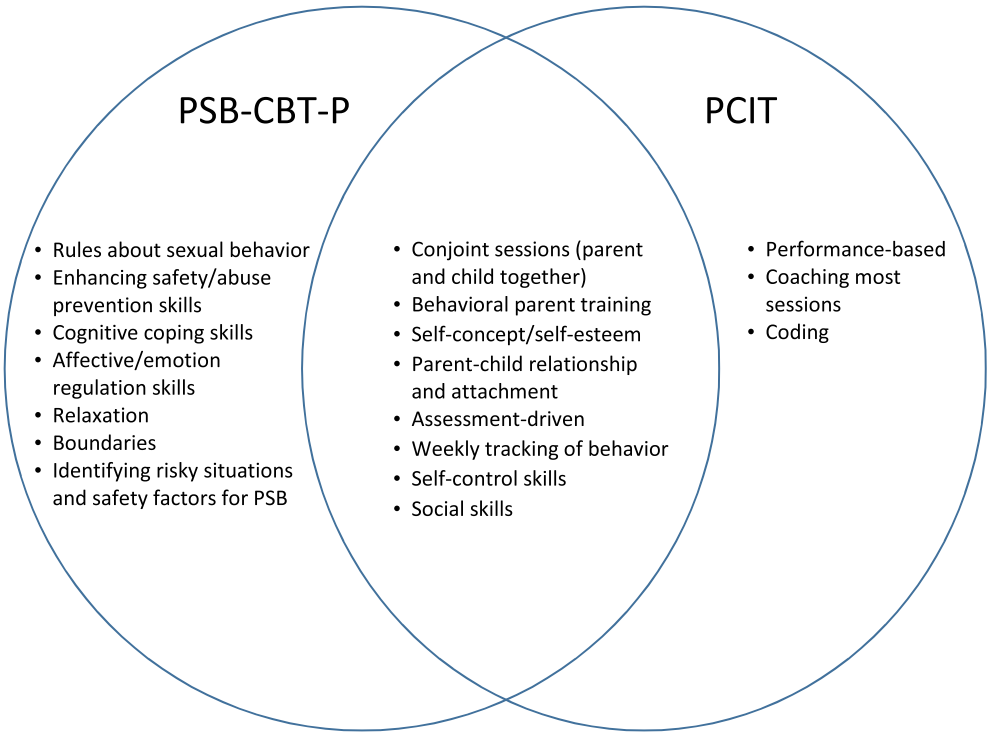

Fig. 1. Overlap of PSB-CBT-P and PCIT treatment approaches.

5. Overview of PCIT-PSB adaptation

Our adapted PCIT treatment model, which we will refer to as PCIT-PSB, infuses the treatment components of PSB-CBT-P into the foundation of PCIT. The adaptation largely builds upon the existing PCIT treatment, and Fig. 1 demonstrates the overlap between PCIT and PSB-CBT-P. For instance, both treatments are family-based and attachment-focused meaning that strengthening the caregiver-child relationship is targeted, caregivers and children are active in session, and caregivers are taught skills to strengthen their relationship with their child. BPT is essential in both treatments, though is more intense in PCIT with most sessions involving active coaching of the caregiver-child dyad. Social reinforcement is emphasized to strengthen child self-concept and self-esteem in both treatments and each relies on weekly tracking of behavior for the progression of treatment. Families can easily report on weekly PSB behaviors as well as other disruptive behaviors. Secondary goals of PCIT, such as teaching child self-regulation and social skills, are explicitly taught in PSB-CBT-P.

Recommendations for PCIT-PSB are provided below. Table 1 presents an overview of the proposed protocol and timeline for coverage of session content. Fidelity to treatment is discussed, along with deviations from existing protocols in the recommended adaptation. Advancement through the stages of PCIT is largely unchanged in the current proposal. As such, caregivers will move from the CDI phase of treatment to the PDI phase when mastery of CDI skills has been met. Graduation requirements also remain the same as in standard PCIT (i.e., ECBI score within one-half standard deviation of the normative mean; mastery of CDI and PDI skills and procedures, and caregiver's confidence in managing child behavior problems). However, to successfully complete PCIT-PSB, evaluation of a child's PSB should fall within the normative range. PCIT-PSB prefaces PCIT with a module that includes: psychoeducation on PSB, sexual development, sex education, and safety (e.g., safety planning and supervision recommendations), abuse prevention, body awareness, and rules regarding private parts. Additionally, coaching sessions will tailor the core PCIT skills to the specific issues of PSB. Assessment considerations, safety planning, didactic suggestions, and coaching guidelines are each addressed below. Given the focus of the current article, assessment and treatment considerations of PSB are emphasized over disruptive behavior as assessment and treatment of disruptive behavior can be found elsewhere within the literature (Eyberg, Nelson, & Boggs, 2008). Further, additional sessions that may be included after the typical course of PCIT are described.

6. Clinical considerations in PCIT-PSB

6.1. Initial and ongoing assessment

As in all evidenced-based treatments, services begin with a focused clinical assessment. This clinical assessment guides clinical decision making, intervention planning, and safety planning. In addition to standard PCIT assessment, an assessment of sexual behaviors is needed as part of PCIT-PSB. Known detailed information for each PSB that has been exhibited is collected. Information about the type of sexual behavior (e.g., showing/looking/touching of a private part) and the onset, triggers, context, responses, course, and duration of the PSB allows a clinician to understand the history, the current impairment, and the possible maintaining function of the behavior. In addition to inquiring about discipline practices for the co-occurring disruptive behavior, it is equally important to assess the responses a caregiver has attempted to reduce PSB. As can be the case in standard PCIT cases, many caregivers are unsure how to respond to inappropriate behaviors, which is perhaps especially true in cases of PSB. For children with PSB, we recommend that an evaluation include a comprehensive overview of family and trauma history. Preschool children with PSB are more likely to have experienced trauma, including maltreatment, and may have an extensive placement history linked to the PSB if involved in child welfare. Therefore, greater emphasis on these areas may be needed for children presenting with PSB. Standard assessment for PCIT-PSB would also benefit from gathering information on the developmental, psycho-social, and medical history of the child. Notably, children with PSB may have had a medical condition influencing or impacted by the PSB, such as a urinary tract infection or yeast infection.

Standard PCIT emphasizes assessment of caregiver stress and coping as they are bi-directionally related to disruptive behavior problems.

Table 1
PCIT-PSB protocol outline and techniques.

Clinical assessment and treatment planning (2 sessions)
Session 1
- Psychosocial intake: family, placement, medical, and developmental history; functional assessment of behavior; sexual development and behavior,[a] history of exposure to sexuality[a] and maltreatment history.
- Measurement of child behavior problems, PSB[a], trauma symptoms, and parent stress.
- Introduction to safety planning, reduce any immediately known risks for future PSB.[a]

Session 2
- Dyadic Parent-Child Interaction Coding System (DPICS; Eyberg, Chase, Fernandez, & Nelson, 2014).
- Continue safety planning and monitoring supervision.[a]
- Clinical decision making for treatment model (e.g., elevated PSB and disruptive behavior with no indication that treating any trauma symptoms first would impact outcomes).[a]

PSB teach (3 sessions)[b]
Sessions 3–4
- Psychoeducation: dispelling myths about PSB in children; sexual development; origins of PSB and disruptive behavior problems.
- Behavior plan (reinforcement plan) for child following private part rules paired with teaching a systematic response for caregivers to manage future incidents of PSB (e.g., calmly stop PSB, ensure safety, acknowledge that a private party rule was broken, reminder of reinforcement plan for following private part rules).

Session 5
- Parent-child session on body awareness, boundaries, private part rules, abuse prevention, and safety

CDI teach (1 session) and coaching sessions (approximately 6 sessions)
Sessions 6–12
- Standard PCIT, CDI teach and coaching sessions with emphasis on labeled praise for boundaries and following private part rules[a]; redirection/distraction and selective attention strategies for self-directed, child PSB in the home[a]; and how to establish boundaries to prevent PSB.[a]
- Include PSB directed toward others in the category of aggressive and destructive play.[a]
- Completion of CDI consists of parent meeting standard CDI mastery.

PDI teach (1 session) and PDI coaching sessions (approximately 6 sessions)
Sessions 13–19
- Standard PCIT, PDI teach and coaching sessions with emphasis on direct commands targeting incompatible behavior with self-directed PSB in the home[a].
- Establishment of an automatic consequence for PSB once in PDI session 4 with House Rules[a].
- Continued use of behavioral reinforcement plan (i.e., behavior chart for following private part rules)[a].
- Completion of PDI and PCIT include subclinical elevations in disruptive behavior problems and PSB[a], parental mastery of CDI skills, the PDI skills and procedure, and parental confidence in managing child behavior.

Additional sessions pending assessment and individual treatment goals[b]
Session 20–24
- Feeling identification and expression
- Self-control and emotion regulation skills
- Understanding sexual abuse
- Family reunification[c]

[a] Represents deviations and points of emphasis not included in the standard PCIT protocol.
[b] Indicates additional modules not included in the standard PCIT protocol.
[c] May require additional sessions and assessment, possible to occur throughout treatment.

Assessment of caregiver stress in cases of PSB is also needed, as stress related to PSB can have direct and indirect effects on the family. For instance, caregiver stress may be related to concern about their child with PSB, the occurrence of PSB with siblings, potential placement changes (e.g., possible change in foster placement, removal from biological home due to PSB with a sibling), treatment setting in which a family may seek assistance (e.g., out-patient, residential, inpatient), and caregiver well-being (e.g., past caregiver trauma history, depression, marital discord surrounding decisions made about the child with PSB).

Information obtained from the intake interview can be supplemented with data collected from standardized assessment measures and observational tools. The Dyadic Parent-Child Interaction Coding System (DPICS; Eyberg et al., 2014) is a structured caregiver -child observational tool developed for use with PCIT. The DPICS is used to assess caregiver-child interactions in varying levels of demand and provides the groundwork for assessment of skills taught and measured in PCIT. In PCIT-PSB, incidents of PSB and boundary violations should be added to the standard assessment of the DPICS, which is a flexible coding system that allows for the addition of categories of specific behaviors of interest. In addition to the measures for child disruptive behavior and caregiver stress (e.g., Eyberg Child Behavior Inventory [ECBI]; Eyberg & Pincus, 1999; Parenting Stress Index-Short Form [PSI-SF]; Abidin, 1995) typically used within standard PCIT, we recommend an additional measures of child sexual behavior, a trauma screening measure, and an assessment of Post-Traumatic Stress Disorder symptoms when warranted. The Child Sexual Behavior Inventory-III (CSBI; Friedrich, 1997) is the only published standardized measure of child sexual behavior with norms. The 38 item measure is normed for children ages 2–12, and the items also correspond to nine domains of sexual behavior: Boundary Problems, Showing Private Parts, Gender Role Behavior, Self-stimulation, Sexual Anxiety, Sexual Interest, Sexual Intrusiveness, Sexual Knowledge, and Looking at Others' Private Parts.

Results from the clinical interviews, observations, and standardized measures facilitate determination of which behaviors and symptoms are impacting functioning and are priorities for safety and treatment planning. PCIT-PSB is designed for children presenting with a broad pattern of disruptive behaviors, including elevated PSB, that are interfering with functioning at home or in the community. High levels of caregiver distress are common, as is a history of trauma experiences. However, if the child presents with PTSD symptoms, particularly re-experiencing symptoms, TF-CBT emphasizing the BPT and PSB components may be warranted (see Allen, 2017, for discussion of TF-CBT for children with PSB). Further, if a child engaged in an isolated incident of interpersonal PSB and the behavior occurred several months ago, it may be beneficial to conduct standard PCIT and include elements of treatment of PSB-CBT-P either briefly at the start, in the middle, or at the end of treatment depending on the significance of the behavior and the concern for the behavior to reoccur.

In addition to the initial clinical assessment, ongoing assessment of behavior is a hallmark of PCIT and PSB-CBT-P. Assessing for behavior concerns and PSB throughout treatment allows for examination of treatment impact and also provides caregivers direct feedback about progress. Specifically, during standard PCIT, the ECBI is administered prior to the start of session each week to monitor externalizing behaviors. As the goal of this treatment adaptation is to target both disruptive behaviors and PSB, sexual behaviors should also be assessed weekly. To decrease the reporting burden, we recommend that three items related to sexual behaviors be added to the end of the ECBI to track PSB. These three items could be the highest frequency items from the CSBI. Alternatively, caregivers could be asked to list up to three sexual behaviors of most concern (as recommended by Friedrich, 2007), and these could be added to the weekly ECBI. To maintain consistency, additional PSB items can be rated on the same Likert and problem scale as ECBI items.

6.2. Safety planning

As mentioned above, the assessment is directly related to the formulation of a family safety plan. As PSB poses risk to the child with PSB and other children, a focus on safety planning to develop and maintain a safe environment that limits opportunity for PSB is important. Children with PSB can often successfully live with other children when caregivers are taught how to create and foster a safe home environment. Safety planning is individualized depending on the context of child and family factors. Ensuring there is a high level of supervision among children can be difficult, and treatment must include an open discussion of barriers and considerations related to supervision. Caregivers who have limited support, work outside the home, or have

multiple children can find supervision challenging. Further, some caregivers believe that they are providing a high level of supervision, when in reality it is insufficient. Safety planning includes providing caregivers with guidelines for supervision. It is important to be specific and direct with families on how to provide "eyes on" supervision at all times. Some examples of recommendations include teaching caregivers how to maintain privacy in the home (e.g., keeping doors closed when changing clothes, knocking on doors before entering, not allowing children to play together without an adult present) and working with the family on sleeping arrangements so that the child will not have an opportunity to be with another child at night (e.g., utilization of door alarms, temporarily moving children into separate bedrooms). Discussion around the necessity for eyes on supervision, how to draw on support to bolster supervision, and overcoming barriers for increased supervision are included in safety planning. Additionally, safety planning allows time for the caregiver(s) and child to create and discuss developmentally appropriate rules in the home so that all family members know the caregivers' expectations and understand what are appropriate activities among family members. Resources to facilitate developing safety plans are available (Silovsky, 2009; www.ncsby.org).

After the safety plan is established, it should be monitored and revised throughout the course of treatment. Direct observation and coaching is fundamental to the PCIT approach. During sessions, the provider should look for opportunities to assess the level of supervision (e.g., child needing to use the restroom, child running out of the room, monitoring the child in the waiting area). These real life opportunities provide the therapist valuable information and offer opportunities to coach application of supervision skills in the moment.

6.3. PCIT-PSB treatment: PSB teach

After completing intake and safety planning sessions, the next phase of the PCIT-PSB adaptation includes three sessions that we conceptualize as *PSB Teach*. Like the traditional teaching sessions of PCIT, *PSB Teach* sessions are designed to provide education specific to PSB. While PCIT teaching sessions traditionally include only caregivers, the *PSB Teach* sessions include components for both the caregiver and the child.

The initial *PSB Teach* session or two are with the caregivers only. Caregivers often have misconceptions about why their children engaged in PSB or incorrect assumptions about how their child may behave in the future; as such, a significant portion of teach also focuses on dispelling any myths or unhelpful beliefs the caregiver holds. The session addresses psychoeducation about typical childhood sexual development, guidelines to determine if a sexual behavior is problematic, and factors that impact PSB in children. Providing caregivers with information on the common origins of PSB (Chaffin et al., 2008; Silovsky, 2009) and directly addressing any questions they may have often helps to change caregivers' misperceptions. Further, caregivers are provided with the opportunity to learn and discuss rules about sexual behavior (e.g., Private Part Rules) and abuse prevention prior to introducing these rules to the children (see Silovsky, 2009). Finally, to maintain appropriate safety practices and decrease future PSB, it is important to educate caregivers on strategies to prevent future PSB, apply the safety plan, manage risky situations, respond to any new instances of PSB, and protect their children from abuse.

Subsequent to completion of the caregiver-only portions of the *PSB Teach*, children are subsequently included. Notably, young children with PSB are often confused about appropriate behaviors in terms of physical space between individuals, privacy, and behaviors related to private parts. Children may have experiences that are, at a minimum, confusing about what is appropriate (e.g., seeing sexual images or behavior on media or in person, sexually abusive experiences). Caregivers are also often uncomfortable with the topic of sexual behavior, do not provide specific rules for these behaviors, and are uncertain how to change privacy rules as toddlers grow into preschool years. Teaching information directly to children about appropriate behavior and safety, including abuse prevention rules, while actively involving their caregivers, addresses these concerns. Specifically, during *PSB Teach*, children are provided education about private part names and functions, what parts are considered private, and are taught specific rules about sexual behaviors (e.g., Private Part Rules, see Silovsky, 2009 or www.ncsby.org). Private Part Rules are safety rules and are taught in terms of rules to follow as well as what to do if someone tries to break a rule with them. Caregivers are guided to help present the information in session and reinforce this in the home. Because young children with PSB often have difficulty with personal space and lack body awareness, *PSB Teach* includes addressing skills for maintaining appropriate physical boundaries. Hula hoops can be used to visually represent boundaries and practice maintaining appropriate distances with others. Caregivers are taught to use the "hula space" term to remind the child outside of session to maintain boundaries. Modifying games such as "Mother may I" allows practice of asking before entering others' personal space. To promote the use of these skills, families are assigned activities to complete between sessions. Although specific assignments may vary based on the needs of the family, as well as the level of other disruptive behaviors of the child, it is important for caregivers to practice the Private Part Rules consistently with their child as well as other children in their home. Integrating family sessions that include siblings may be helpful to further promote safety and appropriate boundaries among family members.

6.4. Child-Directed Interaction (CDI) adapted for PSB

Upon completion of the *PSB Teach* sessions, the family then moves into the standard PCIT protocol, starting with the CDI Teach session. The goal of CDI is to strengthen the relationship between the caregiver and the child. Caregivers of children with PSB often have a wide range of emotions related to their child's sexual and nonsexual behavior. Caregivers may be overwhelmed with feelings of anger, fear, sadness, or confusion, and this can create conflict in the caregiver-child relationship. In foster care situations, caregivers may have a limited history with the child. Caregivers of children with PSB might hold negative perceptions of their child. These and other factors can lead to tension in the caregiver-child relationship. Friedrich (2007) states that PCIT is an effective attachment-strengthening treatment for children with PSB. The author conceptualized that CDI allows the caregiver and child time to support and repair their relationship by spending high quality therapeutic time together. Caregivers can begin to focus on creating a warm and positive relationship that includes appropriate boundaries and healthy touch with their child using the skills taught in the CDI Teach session.

For PCIT-PSB, in addition to the traditional PCIT CDI Teach session content, the clinician should include a few points of discussion specific to children with PSB. The augmentation of the teach session can help guide the caregiver on ways to target PSB in their application of PCIT. Specific labeled praise is effective to reinforce desired behaviors. Therefore, when discussing labeled praises, tailoring the CDI Teach to the family will include telling caregivers to focus praise on following the Private Part Rules and maintaining good boundaries (e.g., "You are doing a wonderful job keeping hula space with me!"; "I love that you asked permission to give your sister a hug; nice job following the private part rules!"). Further, it can be helpful to over-reinforce maintenance of boundaries and Private Part Rules by providing the child with social reinforcers or with other reinforcers such as through behavior charts. This is a modification from standard PCIT protocol, which relies on social reinforcement and does not include tangible reinforcers. The level of disruption created by PSB and the child's responsivity to praise and ability to learn the rules will determine whether and when to introduce tangible rewards such as stickers to address PSB. In keeping with the core components of PCIT, other non-PSB related disruptive behaviors are not addressed until the PDI phase of

treatment.

If maintaining appropriate physical boundaries is a behavioral concern, logistics are important to reinforce suitable boundaries. When setting up time to practice CDI skills in special time, both in session and at home, consider the proximity of the caregiver to the child and the types of PSB the child has demonstrated with adults. As the child is working on boundaries, there may be a need for the child to sit playing in their own chair, rather than a caregiver's lap. The selection of toys may include options with many pieces so the child can easily reach without having to worry about boundaries. Appropriate boundaries are to be mutually determined with the caregiver (e.g., putting an arm around the caregiver shoulder might be allowed but laying their head on the caregiver's chest may not). Finally, the provider should discuss with the caregiver how to respond if boundaries are not maintained during special time (e.g., how and when to redirect vs. needing to stop the play). Redirection will play an important role in CDI to keep the child engaged in an activity. For instance, if the child's problem is touching their own private parts in public, engaging them with a toy will redirect that behavior. The caregiver can then praise the child for following the Private Part Rules by keeping their hands away from their private parts while in public. Direct breaking of Private Part Rules, such as the child grabbing the caregiver's private parts, would constitute one of the situations that requires stopping Special Time, similar to responses to physically aggressive behaviors in standard PCIT. The provider and caregiver can determine how to respond to other behaviors such as repeated boundary infringements, but redirection with differential attention makes the need to stop the play in CDI a very rare occurrence, just as play rarely has to be stopped for aggression during CDI.

Children with PSB will have standard PCIT CDI coach sessions designed to assist caregivers in establishing new patterns of interaction. Coaching is a hallmark of PCIT and sets it apart from other BPT models (Friedrich, 2007). CDI coaching should include guidance for caregivers in real time on how to respond to their child maintaining good physical interactions as well as coaching on modeling good boundaries for their child. Comer et al.'s (2012) PCIT adaptation for children with anxiety disorders was similar in their approach. They infused standard CDI coaching with coaching aimed at promoting skills specific to anxiety. Homework review during the CDI phase should be individualized to assess progress of the implementation of the safety plans and Private Part Rules. This can be accomplished by listing the targeted rules on the homework sheet and having the caregiver report how the child maintained these rules each day. Further, allowing time at the beginning of the session for the child to recite the Private Part Rules and answer questions regarding following the rules in different scenarios will allow ongoing assessment and determining the need to further address the rules and safety planning. The transition from CDI to PDI is consistent with the standardized PCIT protocol based on caregiver mastery of the CDI skills.

6.5. Parent-Directed Interaction (PDI) adapted for PSB

Children with PSB often have difficulty following rules in other settings. In the standard PCIT protocol, PDI introduces components of teaching caregivers' an effective and structured discipline method through the use of effective commands and a timeout sequence for child noncompliance and later introducing house rules to address negative behavior such as aggression. Within PCIT-PSB, clinical considerations in the PDI Teach include teaching the caregiver specific, incompatible commands that may aid in preventing or stopping PSB. For instance, a caregiver may be taught to tell the child “please put your hands on the table,” to prevent the child from having the opportunity to touch their own private parts. It is important to discuss comfort and willingness of a caregiver to provide contingent consequences for noncompliance. Caregivers of young children with PSB may be particularly hesitant to apply consequences to occurrences of PSB, particularly when if the child has a trauma history. Open discussions regarding caregiver thoughts and feelings around discipline can facilitate implementation of PDI skills that are reasonable and beneficial for the child.

When caregiver(s) develop house rules in PDI 4 of the standard PCIT protocol, specific attention should also focus on helping caregiver(s) develop house rules that are relevant to PSB. A house rule is a rule that is established for behaviors that are considered aggressive or destructive, should not occur under any circumstances (e.g., breaking a sexual behavior rule), or are sneaky behaviors. House rules are established to immediately stop a behavior and to provide an immediate consequence (i.e., timeout without a warning statement). For instance, a house rule could be developed around “not touching other people's private parts.” Although the concept of a house rule may have been introduced in the PSB teaching phase of treatment, a caregiver would be limited until PDI when the more formal discipline procedure of timeout is taught. For instance, until this point in treatment, a caregiver would simply inform the child they broke a rule, remind the child they didn't earn their reinforcer because they broke a private part rule, and the caregiver would direct a child to a more appropriate behavior. The formal introduction of house rules is an opportunity to refine the rules to be practiced more directly during the PDI phase. The provider should consider the development and functioning of the child when establishing these rules. For instance, a six-year-old is more likely to be cognizant of breaking a boundary rule than a three-year-old. Also, there might be some exceptions to a boundary house rule, such as asking before hugging a caregiver. Clinical judgment in these situations is warranted and should be seen as an opportunity to assist the caregiver in problem solving issues around PSB and communication with the child. Weekly ECBI scores and assessment of sexual behaviors will inform progress and targets for PDI coaching. As in standard PCIT, live coaching during an outing is optimal. This is particularly helpful for children with PSB since they often engage in PSB with other children, such as on the playground or at a gymnastics class.

6.6. Treatment progress and transitioning to completion of services

Determining when to complete treatment is a joint effort between the provider and caregiver. However, we recommend the standard guidelines for completion of PCIT be followed in PCIT-PSB with the additional requirement that the child have normative rates of sexual behavior. As sufficient progress is made with PDI, it is recommended to re-administer the standardized measures that were completed during the intake assessment (e.g., full CSBI, PSI, DPICS, ECBI). Positive functioning at home and in the community, with assessment scores in the normative range and no ongoing PSB, suggest sufficient treatment progress. Should clinical concerns remain (e.g., scores in the clinical range), providers may consider continuing treatment to target ongoing concerns (e.g., emotion regulation, impulse control) or refer to appropriate treatment (e.g., trauma treatment if PTSD symptoms are elevated). In addition, a discussion focused on managing future behavior needs to incorporate information on continued prevention of PSB and awareness of future risky situations (e.g., unstructured time with large groups of children). Safety planning with the child could be revisited upon completion of treatment. For example, if during treatment the child is separated from their sibling, seeing their sibling could re-trigger PSB. Family sessions to address reintegration or reunification with sibling(s) may prevent reoccurrence of PSB (the impact of the previous PSB on the siblings will obviously influence the planning and timing of such family sessions). It can be helpful provide anticipatory guidance for future developmental milestones, particularly puberty. This discussion can include developmentally suitable strategies to maintain open communication about topics related to not only sex education, but also healthy relationships, friendship development, and decision making throughout childhood.

7. Conclusions and future directions

Young children with PSB are now more likely than ever before to come to the attention of mental health and behavioral health care providers. Child Advocacy Center's have invested in training to recognize PSB in children and to intervene (National Children's Alliance, 2017). However, misconceptions remain prevalent among professionals and the public, hindering access to effective treatment. Efforts to enhance clinicians' accurate understanding of PSB in children accompanied with treatment guidance in the form of an adapted standardized intervention are timely. Specifically, providing an adaptation for a widely disseminated BPT model, PCIT (Eyberg & Funderburk, 2011), improves the utility of an existing intervention to maximize the reach for families dealing with PSB in young children.

The current article provides the conceptualization, rationale and guidelines for adapting the PCIT protocol to address PSB in the context of DBD. Consistent with the PCIT developer's recommendations (Eyberg, 2005), this proposed adaptation maintains the core conceptualization and components of PCIT with the augmentation of PSB-CBT treatment components. This adaptation is recommended due to unique characteristics and safety concerns of PSB. For young children with serious PSB and DBD, PCIT and PSB-CBT-P alone are both insufficient to fully address the presenting problems, which may endanger other children or the child's home or educational placement. This protocol was developed through clinical application of the PCIT and PSB-CBT treatment models and adaptations within active Behavioral and PSB clinics. Examination of outcomes first with systematic case studies, followed by clinical trials is necessary next steps for testing and refining the proposed protocol.

The augmentation of PCIT with existing PSB-CBT for preschoolers has several advantages over other alternatives, such as creating a new treatment, delivering two treatments simultaneously, or providing each stand-alone treatment in sequential order. Chorpita and Daleiden (2014) highlight the importance of a coordinated system delivery model to advance mental health treatments. The empirically informed combination of PSB-CBT for preschoolers and PCIT improves the treatment's applicability and impact within complex service systems. The evidence-informed collaboration between leading researchers and providers in PCIT and PSB is a step forward in improving coordination of services for a uniquely high-risk population. Such coordination will allow for trained PCIT clinicians to receive advanced training that builds upon previously learned skills, reducing duplication of training and treatment provision. It fosters informed treatment planning for providers instead of changes based solely on intuition or clinical comfort. Importantly, the proposed model enhances client experience by participating in a single treatment that utilizes the distinct core components from two proven treatments. Research is needed to fully evaluate PCIT-PSB. Many clinicians may not have experience or training in working with young children with PSB. Therefore, we recommend that PCIT-trained providers seek supplimental training in working with young children with PSB.

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