Treatment programs for children with sexually problematic behaviour: A status report[1]

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Abstract

This article presents an overview of treatment programs for children aged 6 to 12 who present sexually problematic behaviour. The first part of the paper describes the treatment programs; the second part addresses the assessment of these treatment programs' effectiveness, followed by a critical analysis of the assessments themselves; and the article concludes with a discussion of new directions in research concerning children with sexually problematic behaviour.

Key words: treatment program, assessment, sexually problematic behaviour, children

Introduction

Though sexually problematic behaviour in children is not a new phenomenon, very little has been written on the subject. Indeed, the issue would appear to be poorly understood and its scale, underestimated (Pithers & Gray, 1998). Many children display sexually problematic behaviour very early on in their development, and yet to date, few clinicians or researchers have studied the phenomenon (Burton, Rasmussen, Bradshaw, Christopherson & Huke, 1998; Ryan, 1997a). With the knowledge that most sex offenders, both adolescent and adult, first display inappropriate sexual behaviour before reaching adulthood – some as young as five years old (Abel & Rouleau, 1990; Longo & Groth, 1983; Longo & McFadin, 1981; Ryan, 1997a) – it becomes imperative to treat such children as early as possible, both to prevent future victimization and to ensure that the problematic behaviour does not worsen (Araji, 1997; Bengis, 1997; Bentovim, 2002; Lane, 1991; Ryan, 1997b; 2000). According to data from social services agencies, 13 to 18 percent of aggressive sexual gestures made toward other children can be attributed to children 12 years old and younger (Pithers & Gray, 1998). Because the children who initiate such inappropriate sexual behaviour have not yet reached adolescence, they are too young to be charged under the law, too high-risk to place in foster homes with other children, yet too troubling to ignore. This is the reality that has driven researchers and clinicians to develop treatment programs for children with sexually problematic behaviour.

Although there is a wide variety of labels used to define children with sexually problematic behaviour, there is some agreement among practitioners and researchers concerning specific sexual behaviours that can be characterized as sexually problematic. A general definition involves behaviours that (a) occur at a frequency greater than would be developmentally ex-

pected, (b) interfere with a child's development, (c) occur between children of different ages or developmental abilities, (d) involve several types of sexual activity, (e) are pervasive across time and situation, (f) recur repeatedly, and (g) are unresponsive to adult intervention and supervision (Chaffin, Letourneau & Silovsky, 2002; Gil, 1993a; Gray, Busconi, Houchens & Pithers, 1997; Gray, Pithers, Busconi & Houchens, 1999; Hall & Mathews, 1996; Hall, Mathews & Pearce, 1998, 2002; Johnson, 1999). As some authors have cautioned, however, it is important to note that sexual behaviour in children varies across cultures and social groups, and such variations may consequently influence what constitutes either natural or problematic childhood sexual behaviour (Friedrich, Sandfort, Oostveen & Cohen-Kettenis, 2000; Gil, 1993a; Haugaard & Tilly, 1988; Larsson, Svedin & Friedrich, 2000; Sandfort & Cohen-Kettenis, 2000). As Larsson and his colleagues (2000) assert, "the degree of concern adults experience in response to a child's behaviour is often determined by the cultural context in which the particular family lives" (p. 256).

Most practitioners and researchers have proposed a continuum of sexual behaviours to demonstrate the progression of natural and healthy to sexually problematic behaviours (Berliner, Manaois & Monastersky, 1986; Bonner, Walker & Berliner, 1999; Chaffin et al., 2002; Hall & Mathews, 1996; Hall et al., 2002; Johnson, 2002; Johnson & Feldmeth, 1993; Pithers, Gray, Busconi & Houchens, 1998). The common thread among these continuums is the view that sexually aggressive behaviours fall at the extreme end of the continuum and are most resistant to treatment.

Although there is neither one specific profile for children with sexually problematic behaviour nor a clear pattern of demographic, psychological, familial and social factors, several findings emerge from research performed over the past ten years. These children live in dysfunctional family environments marked by chronic distress factors (i.e., poverty, sexual abuse or its perpetration within the extended family, arrest for criminal behaviour, mental health problems), and many of them have been maltreated, both sexually and physically. They also display emotional and behavioural problems (i.e., conduct disorders, hyperactivity, impulse dysregulation), and many experience learning disabilities and lack social skills. Furthermore, there is also evidence of an impaired attachment between parent and child (Bonner et al., 1999; Friedrich & Luecke, 1988; Gagnon, Begin & Tremblay, submitted; Gray et al., 1997, 1999; Hall & Mathews, 1996; Hall et al., 2002; Johnson, 1988, 1989; Pearce, 2003; Pithers et al., 1998; Silovsky & Niec, 2002).

The recognition that children with sexual behaviour problems are not a homogenous group supports the notion that different treatment approaches may be required for various types of sexually problematic behaviour (Araji, 1997; Cantwell, 1995; Johnson, 2002; Johnson & Feldmeth, 1993; Pithers et al., 1998). This paper discusses the importance of treating children with sexually problematic behaviour. Within this context, the paper will cover 1) the types of treatment programs offered, 2) treatment efficacy research, 3) a critical analysis of treatment efficacy research, and 4) recommendations and conclusions.

Description of treatment programs for children with sexually problematic behaviour

This first part presents (a) an overview of the situation, (b) the main avenues of treatment described in programs for children with sexually problematic behaviour (treatment of the children, their parents, and their families), and (c) considerations specific to existing treatment programs.

Overview

While interest by professionals in sexually problematic behaviour in children has increased significantly in the last 15 years, the first survey of programs for children with such behaviour was carried out only in 1994 in the United States. The Nationwide Survey of Treatment Programs counted 390 programs in the U.S. that offered services to children presenting inappropriate sexual behaviour (Freeman-Longo, Bird, Stevenson & Fiske, 1995). However, other authors have estimated the number of programs designed specifically for children with sexually problematic behaviour to be far more limited – between 12 and 35 (Araji, 1997; Johnson, 1993a; Lane, 1991). Moreover, few programs have been systematically documented and assessed, and of those that have, few appear in scientific papers. Thus for the most part, the available literature provides only program descriptions and clinical opinions on their effectiveness.

The first specialized treatment program, the California-based Support Program for Abuse-Reactive Kids, was developed in 1985 under the direction of Kee MacFarlane at the Children's Institute International, a private non-profit organization for the treatment of child abuse (Araji, 1997; Johnson, 1993b). Since then, this program has been adapted by other authors, and other programs have been developed in the U.S., Canada, and Australia (Ballester & Pierre, 1995; Berliner & Rawlings, 1991; Bonner, Walker & Berliner, 1999; Burton et al., 1998; Cunningham & MacFarlane, 1991, 1996; Friedrich, 1990; Hindman, 1994; Johnson, 1993b; Johnson & Berry, 1989; Gil, 1993c; Gray & Pithers, 1993; Lane, 1991; Lane & Lobanov-Rostovsky, 1997; Services à l'enfance et à la famille, 1995).

In general, programs to treat children with sexually problematic behaviour have the same end goals: to stop the problematic behaviour from getting worse, to prevent future victimization and the appearance of other aggressive behaviours, and to foster the development of more appropriate social and personal comportment (National Adolescent Perpetrator Network, 1993).

The services offered to participants in these programs are generally structured around three modes of treatment – individual, group, and family. The most widespread therapeutic approach is to directly target the problematic sexual behaviour. This "behaviour-specific" approach usually has two components – one focused on therapy and support for the child and the parents, the other focused on education (development of knowledge related to sexuality and of social skills, improvement of self-control and self-esteem, parenting skills, etc.). In addition, the programs employ a combination of treatment methods which fall within a conceptual framework that, while eclectic, is strongly influenced by a cognitive-behavioural orientation (Freeman-Longo et al., 1995; Knopp, Freeman-Longo & Lane, 1997).

Avenues of treatment

This section describes the three primary avenues of treatment in programs for children with sexually problematic behaviour: treatment of children, treatment of parents, and treatment of families.

Treatment of children

While group therapy is by far the most frequently employed method for treating children with sexually problematic behaviour, individual therapy is also used when necessary (Ballester & Pierre, 1995; Berliner & Rawlings, 1991; Bonner et al., 1999; Burton et al., 1998; Cunningham & MacFarlane, 1991; 1996; Friedrich, 1990; Hindman, 1994; Hoyle, 2000; Johnson, 1993b; Johnson & Berry, 1989; Gil, 1993c; Gray & Pithers, 1993; Lane, 1991; Lane & Lobanov-Rostovsky, 1997; Service à l'enfance et à la famille, 1995).

When used in tandem with group therapy, individual therapy helps the child form a relationship of trust with the therapist, deal with previous trauma, and work on internal conflict resolution (Burton et al., 1998; Gil, 1993c; Service à l'enfance et à la famille, 1995). According to Burton and his colleagues (1998), children more readily speak about their sexually problematic behaviour during individual sessions and are more likely to ask questions about sexual development and sexuality. Furthermore, when combined with group therapy, individual therapy prepares the child for integration into the group setting, clarifies the subjects dealt with in group sessions, and more thoroughly explores problems specific to the child (Burton et al., 1998; Gil, 1993c).

When group sessions are not available or when the child cannot attend group therapy because of cognitive impairment or a major mental health problem, individual therapy becomes the primary treatment method. Moreover, with children who present sexual behaviours that do not involve other children (e.g., compulsive self-stimulation), individual therapy is preferable (Gil, 1993c).

Group therapy helps to break isolation because children are able to connect with other children through their common experiences, allowing them to speak about their defense mechanisms, especially minimization, denial, and rationalization. In addition, a group setting allows children to share their experiences, thereby gradually dissolving barriers of mistrust of the therapeutic context. Because it allows children to develop bonds, to assert themselves with others in a respectful manner, and to collectively express their feelings and fantasies through games and role playing, the group setting provides children with positive socialization experiences (Burton et al., 1998; Cunningham & MacFarlane, 1996; Johnson, 1993b). Such experiences are an important facet of treatment because they help to improve a child's self-perception (Johnson, 1993b; Pithers, Gray, Cunningham & Lane, 1993). Moreover, the group's use of identification and positive reinforcement, and its suggestion of new strategies for conflict resolution, encourages the adoption of more appropriate behaviours. The children thus help themselves, and their feedback on the various behaviours, feelings, and thoughts of the other children becomes a powerful instrument of change (Ballester & Pierre, 1995; Burton et al., 1998; Cunningham & MacFarlane, 1991, 1996; Johnson, 1993b; Johnson & Berry, 1989; Pithers et al., 1993).

Both forms of therapy for children with sexually problematic behaviour – individual and group – use various educational techniques to teach, among other things, personal and social skills in an effort to reduce the frequency of inappropriate sexual gestures (Ballester & Pierre, 1995; Berliner & Rawlings, 1991; Bonner et al., 1999; Burton et al., 1998; Cunningham & MacFarlane, 1991, 1996; Friedrich, 1990; Johnson, 1993b; Gray & Pithers, 1993; Hindman, 1994; Lane, 1991; Service à l'enfance et à la famille, 1995). The assumption underlying these techniques is that learning is a driving force in the acquisition and persistence of sexually problematic behaviour (Ballester & Pierre, 1995; Johnson, 1993b; Friedrich, 1991). The treatment of children with such behaviour involves four principal techniques: prevention of relapse, teaching social skills, self-control, and sex education.

Prevention of relapse is a specific cognitive and educational therapeutic technique based strongly on a technique developed for adolescents (Gray & Pithers, 1993; Lane, 1991; Pithers, Becker, Kafka, Morenz, Schlank & Leombruno, 1995). Prevention of relapse draws on social learning theories which postulate (a) that sexually problematic behaviour is caused not by any one factor but by a series of factors involving a number of spheres (cognitive, affective, biological, and social), (b) that an inappropriate sexual gesture is an unsuitable response to a group of stress factors, and (c) that problematic sexual behaviours are generally preceded by a chain of events and rarely occur without warning signs (Burton et al., 1998; Rasmussen, Burton & Christopherson, 1992). Therapists using this technique help children identify the thought and

behavioural processes that have led to their sexually problematic behaviour; they also help them learn to control their sexual gestures by developing a cognitive understanding of the history of their sexually problematic behaviour and strategies to break the behavioural cycle (Ballester & Pierre, 1995; Cunningham & MacFarlane, 1991, 1996; Johnson, 1993b; Gray & Pithers, 1993; Lane, 1991; Lane & Lobanov-Rostovsky, 1997).

Teaching social skills is based on the notion that children with sexually problematic behaviour often have poor social skills. Many such children lack the tools that would allow them to interact with other people in a positive fashion and to avoid negative responses. In addition to its use of various didactic methods, this technique employs activities designed to provide children with the skills to develop and maintain healthy social networks. These activities include role playing, expressing emotions, modelling, reinforcement, feed-back, assertiveness, and conflict resolution strategies (Ballester & Pierre, 1995; Cantwell, 1988; Friedrich, 1991; Johnson, 1993b; Lane, 1991; Lane & Lobanov-Rostovsky, 1997; Shaw, 1999).

The technique of self-control acknowledges that children with sexually problematic behaviour have trouble controlling their anger and impulses in situations of conflict. Children are thus taught to better use their inner voices to recognize the irrational ideas upon which their inappropriate behaviours are based (e.g., "My parents are always on my back." or "It's not my fault; they put me in a foster home.") and replace them with more rational statements (e.g., It's true that I don't always listen to my parents." or "I often yell insults at others."). The children subsequently learn to formulate new statements, which prepare them to better react in problem situations (e.g., "I am able to control myself."). Further, they learn to control their aggressive and impulsive behaviour and to manage their emotional outbursts (Ballester & Pierre, 1995; Cunningham & MacFarlane, 1996; Johnson, 1993b; Lane, 1991; Lane & Lobanov-Rostovsky, 1997).

The last technique, sex education, postulates that a lack of knowledge about sexuality contributes to inappropriate sexual activities. Children are taught about normal sexual functioning as well as the feelings, values and attitudes that children have with respect to sexuality. Using didactic tools, images, and books, this technique fosters a sexuality that is healthy, positive, consensual, and appropriate to the developmental age of the child (Ballester & Pierre, 1995; Burton et al., 1998; Johnson, 1993b; Shaw, 1999).

In addition to educational therapeutic techniques, these programs also use play therapy (Ballester & Pierre, 1995; Bonner et al., 1999; Johnson, 1993b). Through the development of an interpersonal relationship between therapist and child, play therapy fosters an exploration of the inner self, the expression of emotions, and increased awareness (insight); it also provides the child with a therapeutic emotional experience. According to Murdock (1991), there are two reasons for using play therapy with children: (a) children are limited in their ability to verbalize their thoughts and feelings because of their incomplete cognitive development, and (b) play is children's natural mode of communication.

Treatment of parents

Treatment programs (individual and/or group therapy) pay special attention to parents of children with sexually problematic behaviour, offering them services that are specific to their own needs[2] (Bonner et al., 1999; Burton et al., 1998; Cunningham & MacFarlane, 1996; Friedrich, 1990; Johnson, 1993b; Johnson & Berry, 1989; Gray & Pithers, 1993; Griggs & Boldi, 1995; Hindman, 1994; Lane 1991; Lane & Lobanov-Rostovsky, 1997; Pithers et al., 1993).

Individual therapy is aimed at helping parents identify and express their feelings with respect to their children's sexual gestures. Parents can be so embarrassed by their children's sexually problematic behaviour that they will deny, minimize, or dramatize (Cunningham & MacFar-

lane, 1996). Individual therapy allows parents to gain an awareness of the issues that have created certain barriers to their personal development and that have led to their living in a dysfunctional system. It also fosters an awareness of their own attitudes and behaviours, which may influence the persistence of sexually problematic behaviour in their children (Berliner & Rawlings, 1991; Burton et al., 1998; Lane & Lobanov-Rostovsky, 1997).

Among parents, group therapy is aimed at developing a better understanding of the problems surrounding inappropriate sexual behaviour in children (Gil, 1993c; Lane & Lobanov-Rostovsky, 1997). The parents of such children are more likely to use parenting techniques that reinforce problematic and aggressive behaviours (sexual and non-sexual) and to ignore children's positive social behaviours. Moreover, the context of the group setting allows parents to develop a better understanding of child sexuality and of the inappropriate sexual behaviour manifested by their children (Burton et al., 1998; Johnson & Berry, 1989). Finally, group sessions give parents a chance to make friends and establish a support system (Cunningham & MacFarlane, 1996).

Programs make use of a parental training technique based on the hypothesis that teaching behaviour modification strategies to parents (both their own behaviour and that of their children) will lead to a transformation in parent-child interaction and, subsequently, an improvement in the child's social and emotional adjustment (Webster-Stratton & Hooven, 1998). This technique improves parenting skills by helping parents adopt attitudes and parenting methods that contribute to reducing inappropriate sexual behaviours and replacing them with appropriate behaviours. With better parenting skills, parents gain external control, especially through increased supervision and the creation of a secure family environment, which reduces the risk of sexually problematic behaviour occurring (Burton et al., 1998; Friedrich, 1990; Gil, 1993c; Griggs & Boldi, 1995; Lane, 1991; Rasmussen et al., 1992).

Treatment of families

An integral part of many programs is family therapy. This type of treatment occurs within a perspective in which the family is viewed as a system that tends to maintain an equilibrium – in particular, a system in which a child's sexually problematic behaviours are perpetuated by both parent and child.

Most of the programs offer family therapy in addition to group and individual sessions (Berliner & Rawlings, 1991; Burton et al., 1998; Cunningham & MacFarlane, 1996; Friedrich, 1990; Gil, 1993c; Griggs & Boldi, 1995; Lane & Lobanov-Rostovsky, 1997; Service à l'enfance et à la famille, 1995; Thomas, 1997). Family therapy not only provides an understanding of child development and children's conflict-management strategies, it also helps to correct cognitive distortions and myths learned within the family. The therapy involves any siblings who have been affected, either implicitly or explicitly, by a child's sexually problematic behaviour. This type of treatment facilitates new methods of communication and develops a support system to help the child break the cycle of problematic behaviour (Burton et al., 1998; Gil, 1993c; Shaw, 1999). In addition, since most sexually problematic behaviour takes place within the family system (immediate or extended), and because these children are particularly sensitive to and influenced by the family dynamic (dysfunctional environment, family arguments, physical violence, etc.), it is essential that families receive support and information to understand the nature of the inappropriate behaviour and to alleviate the often paralyzing guilt that parents feel (Gil, 1993c; Friedrich, 1990; Service à l'enfance et à la famille, 1995). Indeed, the scientific literature shows that even highly dysfunctional families possess strengths that can be mobilized. The treatment programs focus on these strengths and give families the tools they need to effectively support and supervise their children (Friedrich, 1990; National Adolescent Perpetrator Network, 1993; Pithers & Gray, 1998; Shaw, 1999).

It is advisable that siblings take part in family therapy sessions so they can better understand the interactions between members of the family, express their discomfort and feelings, and dispel erroneous notions about sexuality and sexually problematic behaviour (Burton et al., 1998). However, while in some cases the needs of siblings may be fulfilled through family therapy, in families where a sibling has been a victim of the inappropriate sexual behaviour, services such as individual or group therapy designed specifically for child victims will better fulfill these children's needs (Johnson & Berry, 1989).

Program-specific considerations

While all the programs have similar end goals, treatment methods, and therapeutic techniques, they differ considerably with respect to their duration and the number of sessions they offer. Program length varies from 12 weeks to 24 months (60 to 90 minutes per weekly session). The programs' target clienteles are generally boys and girls 6 to 12 years old (Ballester & Pierre, 1995; Berliner & Rawlings, 1991; Bonner et al., 1999; Gray & Pithers, 1993; Lane, 1991; Lane & Lobanov-Rostovsky, 1997; Service à l'enfance et à la famille, 1995); some programs also treat preschoolers aged 4 to 5 years (Burton, 1998; Cunningham & MacFarlane, 1991, 1996; Friedrich, 1990; Johnson, 1993b; Hindman, 1994); and others also offer services to preadolescents 13 years old (Friedrich, 1990; Johnson, 1993b; Johnson & Berry, 1986).

Formation of treatment groups is based on children's developmental age: preschool (3 to 5 years old), school-age (6 to 9 years old), and preadolescent (10 to 13 years old) (Araji, 1997; Burton et al., 1998; Gray & Pithers, 1993; Johnson, 1993b; Lane, 1991). Clinicians (Cunningham & MacFarlane, 1996; Johnson, 1993b; National Adolescent Perpetrator Network, 1993) stress the importance that treatment occurs in same-sex groups in order to foster expression and support among peers, while other authors (Bonner et al., 1999; Pithers et al., 1998) maintain that boys and girls of this age (6 to 12 years old) can function together within the same group.

Finally, the treatment programs also vary in the degree of participation of adults close to the child. While parental involvement is considered essential by most authors (Bonner et al., 1999; Burton et al., 1998; Cunningham & MacFarlane, 1996; Friedrich, 1990; Johnson, 1993b; Johnson & Berry, 1989; Gray & Pithers, 1993; Griggs & Boldi, 1995; Hindman, 1994; Lane 1991; Pithers et al., 1993, 1998), their rate of involvement is poorly documented. Moreover, given that a considerable number of children who display problematic sexual behaviour are placed in foster care, few programs provide details about the level of involvement of other adults who play significant roles in the children's lives (i.e., foster parents, educators, social workers, etc.). In this sense, Ryan (1999) underscores the complexity of treating children because of the many systems involved (youth protection, foster home, biological family, school, etc.). The influence of such systems sometimes supports treatment and sometimes hinders it. It is thus important to evaluate the extent to which these various systems are included in the treatment program (Ryan, 1998).

Treatment efficacy research

Despite the growing number of specialized treatment options for children with sexually problematic behaviour, the scientific literature is striking in its scarcity of treatment efficacy research. Moreover, the studies which do exist are riddled with methodological pitfalls that limit the scope of their results. Nevertheless, a review of the literature has uncovered important and useful information about the treatment of children with sexually problematic behaviour, illustrating the complex, multidimensional nature of the problem itself and of carrying

out clinical research among these children. Our review revealed only one unique case study and two randomized control trials of treatment programs for children with sexually problematic behaviour.

Kolko (1986) carried out a unique case study in a hospital environment describing the social skills training of an 11-year-old boy with sexually problematic behaviour. Kolko developed a social skills training program based on a functional analysis of socially problematic behaviour; the program targeted four behaviours: tone of voice, eye contact, physical gestures, and verbal content. The results showed clinical improvements (i.e., without a statistical analysis) when comparing pre- and post-training tests of social adjustment (score on the Weekly Global Social Adjustment Ratings – WGSAR) and of relationships with peers (score on the Matson Evaluation of Social Skills of Youngsters – MESSY). In addition, the improvements were maintained during the 12-month period following the boy's participation in the program. Finally, a significant improvement between the pre-treatment test and the follow-up was observed with respect to both behavioural problems and sexually problematic behaviour (score on the Child Behavior Checklist – CBCL). While the scope of these results is limited because of the nature of the study (unique case study), the author concluded that social skills training had a positive effect in reducing inappropriate sexual behaviour. According to Brown and Kolko (1998), the results also raised the question of whether or not treatment specific to sexually problematic behaviour is necessary.

In another study, Pithers and his colleagues (Pithers & Gray, 1993; Pithers, Gray, Busconi & Houchens, 1998) compared the effectiveness of group cognitive-behavioural therapy with group expressive therapy. They studied 127 children aged 6 to 12 years with sexually problematic behaviour and their parents. Subjects were randomly assigned to one of the two treatment methods. The cognitive-behavioural therapy employed an approach that focused on relapse prevention and that included external supervision and a relapse prevention team. This team – created to support the development of a preventative lifestyle – consisted of the child, the parents, therapists, and selected people from the child's and parent's circle. The expressive therapy used a variety of techniques to deal with assertiveness, self-esteem, decision-making, sexuality, and social skills, but it did not include a relapse prevention team. Both treatments took place over 32 weeks (90-minute sessions for the children, with simultaneous sessions for the parents). In addition, the groups of children were divided according to age – one group for 6-to-9-year-olds and another for 10-to-12-year-olds.

The overall program results showed a significant reduction in sexually problematic behaviour among 30 percent of the children after 16 weeks of treatment (score obtained on the Child Sexual Behavior Inventory – CSBI). Of these children, participants in the cognitive-behavioural group showed a significantly greater reduction in sexually problematic behaviour than participants in the expressive therapy group. However, 3.2 percent of the children showed an increase in sexually problematic behaviour. The unified data showed that after one year, behavioural problems had diminished (assessed using the CBCL, CSBI, and the Eyberg Child Behavior Inventory – ECBI). The authors attributed the persistence of these improvements to the ability of the families to develop and maintain a healthy family environment and to post-program support by other families who participated in the group sessions. The authors felt that even though certain stress factors may remain in the family environment, it is possible for families to maintain a preventative lifestyle. This finding is indicative of parents' and children's potential to change when they have access to treatment programs that make use of their strengths to promote a preventative lifestyle rather than those that focus only on the elimination of the sexually problematic behaviour (Pithers & Gray, 1993).

In addition, Pithers and his colleagues (1998) observed that irrespective of the type of treatment (i.e., group cognitive-behavioural therapy or group expressive therapy), children with

sexually problematic behaviour of an aggressive nature demonstrated less change than children with unaggressive sexual behaviour. They also stressed the importance of parental participation in the treatment to maximize program effectiveness and to present positive models.

More recently, a study by Bonner et al. (1999) compared the respective effectiveness of cognitive-behavioural therapy and psychodynamic therapy on 201 children and their parents. The subjects, 6 to 12 years old, were randomly assigned to one of the two methods and took part in 12 group sessions. Cognitive-behavioural therapy is a structured approach aimed at behaviour modification by helping subjects to recognize inappropriate sexual gestures, to abide by certain rules, to improve their self-control, to learn about sexuality, and to prevent relapses. Psychodynamic therapy, based on play therapy, focuses on the expression of emotions, increasing self-awareness (insight), transference, and limit setting. The children's behaviour was assessed by their caregivers at the beginning of the treatment, at the end, as well as one and two years post-treatment. The authors reported significant post-test improvements on the CSBI and the CBCL for both groups of children (cognitive-behavioural and psychodynamic therapy) and with respect to sexual behaviour, social skills, and behavioural and affective problems (score on CBCL and CSBI). The authors pointed out that there was no relationship between the results obtained and the type of treatment, i.e., neither treatment was significantly more effective than the other. Results from the two-year post-treatment telephone follow-up indicated that roughly the same number of children from each group (15 percent from the cognitive-behavioural therapy group and 17 percent from the psychodynamic therapy group) had made inappropriate sexual gestures after participating in the program. Of note, however, is the program withdrawal rate: 63 percent of participants completed 9 of the 12 sessions, 56 percent responded to the post-test, and only 29 percent of parents completed the two-year follow up. In short, Bonner et al. (1999) concluded that both therapeutic approaches appeared to be effective in reducing sexually problematic behaviour in children, though they stressed that without a control group, it was impossible to determine with certainty if the improvements were attributable to the treatment program.

Critical analysis of treatment efficacy research

Because of the limited number of studies of treatment programs for children with sexually problematic behaviour and of the limitations of those that do exist (single measure of effectiveness, few details about nature of program, short follow-up period, small sample size, lack of control group, high rate of program withdrawal, imprecise assessment techniques, etc.) one cannot draw any meaningful conclusions about the effectiveness of the programs themselves. Overall, the three studies to date have reported reductions in sexually problematic behaviours regardless of the treatment method employed. However, it is impossible to say whether the reduced levels of sexual behaviour were actually due to the treatment program. Many questions thus remain, notably with respect to the therapeutic processes that were employed and the individual, familial, or contextual variables that may have played a mediating or moderating role in treatment efficacy.

Beyond the strict question of effectiveness, it is also relevant to question the theoretical, conceptual, and methodological limits of these studies. While a proliferation of clinical and scientific studies of these children has led to the development of the programs currently being offered, the lack of an underlying theoretical basis for most of these programs is a clear indication of the "atheoretical" nature of these studies. In this sense, the lack of a functional definition of children who manifest sexually problematic behaviour is a considerable limitation – one that future studies must address (Araji, 1997; Horton, 1996; National Adolescent Perpetrator Network; 1993).

The lack of controlled studies in this area significantly limits the scope of any conclusions that can be made. Randomized trials with a no-treatment control group have not been conducted. Studies that use control groups are needed in order to define the characteristics of different types of children within a heterogeneous population, to better understand the problem of sexually problematic behaviour, and to offer programs that fulfill the needs of these clients. However, because health and social service agencies are highly resistant to the notion of randomly assigning clients to different types of treatment (Bonner et al., 1999), few researchers use control groups. That said, it would be worthwhile to use comparison-group designs as potential alternatives to randomized control trials or to study groups of children who do not complete treatment (Finkelhor & Berliner, 1995). Such groups could help researchers better understand both the problem and the clientele involved.

With respect to indicators of effectiveness, reduction in sexually problematic behaviour was the benchmark of choice. But, while all the authors stressed the importance of treating a wide array of targets, it would be important to broaden the assessment of both program effectiveness and the methods of measuring it to include other clinical indicators (i.e. indicators such as improvement of social skills, increase in knowledge of sexuality, and improvement in control of impulses). In this respect, the development of valid and reliable psychometric instruments would remedy the current lack of standardized tests to measure sexually problematic behaviour in children. While most of the studies used the CSBI (Friedrich et al., 1992) to measure sexual behaviour, there is no scale that measures the degree of inappropriateness or the seriousness of sexual behaviour observed in children. This lack of a standardized test means that treatment effects cannot be reliably assessed (Bonner et al., 1999). However, such tests must be conceived and designed according to both our current knowledge of this clientele and the data that would be obtained through controlled studies.

Given the many levels upon which children with sexually problematic behaviour are affected, a thorough and complete evaluation (clinical interview, standardized questionnaires, etc.) would contribute not only to a better understanding of the phenomenon but would also help health and social services agencies to better direct children to the treatment appropriate to their needs. In this respect, Meyer et al. (2001) point out that in assessing a complex behaviour, the best strategy is to use multiple sources of information (i.e., the initiating child, the parents, child victims, siblings, teachers, social workers, etc.).

Moreover, while most programs consider parental participation an essential and significant contribution to the treatment, no data on the rate and quality of parental participation exists. This factor takes on even more importance given that many studies suggest parental influence is a mediating factor in treatment effectiveness (Gray & Pithers, 1996, cited in Araji, 1997). Along similar lines, treatment programs tend to take very little account of the other systems in a child's life (school, youth protection agencies, hospitals, etc.) and of their influence on the child. However, there are new studies that compare various treatment methods – notably, one that favours concomitant parental participation in a program designed for children, and another that involves different systems in each phase of the treatment – which appear to be moving in relevant directions.

Finally, to date there has been no study of program implementation. If a program's implementation lacks intensity (i.e., frequency and number of sessions), it is difficult to judge whether or not the program is responsible for any changes observed among the participants. That said, an explicit articulation of the theoretical underpinnings of the program would clarify the links between any mediating factors and the program's objectives. For example, when developing treatment programs, the presumed links between an increase in knowledge of sexuality, in social skills, and in impulse control, on one hand, and a reduction of sexually problematic behaviour on the other, should be analyzed in greater depth. Though under-utilized, the relevance of

assessing program implementation has been well established, especially for programs in their early stages (Weiss, 1998). Program implementation studies help to advance our knowledge of the issue of children with sexually problematic behaviour, especially in that they contend with certain theoretical, conceptual and methodological limitations. The assessment of program implementation would also provide more evidence-based answers to certain questions, such as: 1) does the program as implemented comply with the initial plan?, 2) does the clientele being treated correspond to the target clientele?, 3) what are the characteristics of the clients referred to treatment?, 4) do the participants (children and adults) demonstrate resistance to the program?, 5) do the absences or withdrawals of participants bother the remaining participants?, 6) what factors are associated with a relapse of sexual behaviour?, 7) does the treatment's effect differ depending on the type of child?, or 8) would a support and follow-up service for the children and their families help reduce the risks of relapse?

Conclusion

The available scientific literature illustrates the embryonic nature of treatment programs for children with sexually problematic behaviour and of the assessment of their effectiveness.

In summary, although the treatment approaches described previously have not been empirically demonstrated as effective models for intervention, the knowledge and experiences of the authors can be helpful in identifying common themes and issues with respect to services for children with sexually problematic behaviour.

Based on clinical practice and on empirical data suggesting that parental characteristics act as mediating variables in sexually problematic behaviour of children, researchers and practitioners have concluded that treatment for these children should involve their caregivers (Araji, 1997; Bonner et al., 1999; Chaffin et al., 2002; Gil, 1993a; Pithers et al., 1998). Moreover, parental participation is vital because parents foster positive changes in their children's behaviour by helping them both to integrate what they have learned – especially in terms of socially positive behaviour – and to acquire more control over their own behaviour (Ballester & Pierre, 1995; Berliner & Rawlings, 1991; Bonner et al., 1999; Cunningham & MacFarlane, 1996; Friedrich, 1995; Gil, 1993c, 1993c; Johnson, 1993b; Johnson & Berry, 1989; Pithers et al., 1998).

In addition, from a scientific point of view, we cannot currently draw any conclusions as to the effectiveness of therapeutic treatment programs for these children. It goes without saying that the lack of consensus on a definition of sexually problematic behaviour and the numerous methodological limitations that plague the assessment of program effectiveness are detrimental to the development of research protocols in this area. While the three studies examined previously demonstrated improvements between the beginning of treatment and the end, none of them could attribute the observed changes to participation in the programs. It was also difficult to attribute the observed changes to the therapeutic programs because no data on real level of participation was collected. Moreover, the assessment of program effectiveness did not systematically mention iatrogenic effects. It would therefore be advisable that future programs better document their effects, paying particular attention to the characteristics of children who show improvements, to those who show no change, and to those whose behaviour deteriorates during treatment.

In short, despite the many obstacles, more studies are needed in order to improve our knowledge of children's sexually problematic behaviour, to prevent such behaviour from worsening,

and to provide treatment that responds to the specific needs of these children and their environments.

Notes

1. This article was written as part of doctoral studies undertaken by the lead author. We would like to thank the « Conseil québécois de la recherche sociale » for its financial support during these studies.
2. By "parent" we mean any adult responsible for a child: biological parents; foster or adoptive parents; educators in rehabilitation homes, group homes, or rehabilitation centres; grandparents, etc.

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