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Commentary on "Evidence-based Screening, Assessment, and Treatment of Sexually Abused Children: A Multidisciplinary Perspective"

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Commentary

Objectives

Sexual behavior in children can be normative or problematic and is not always the result of childhood sexual abuse. Screening tools can be helpful in identifying abuse and trauma-related symptoms, but there is no single screening tool that will definitively differentiate between problematic sexual behavior associated with exposure to childhood sexual abuse and other psychiatric conditions. Childhood sexual behaviors are influenced by a multitude of factors. Each case must be assessed, conceptualized, and treated in an individualized and culturally sensitive manner within a multidisciplinary setting. Guidance from experienced interdisciplinary clinicians in psychiatry, psychology, and social work will contribute to evidence-based care for problematic sexual behaviors [1, 2].

Methods

At the 68th Annual Meeting of the American Academy of Child and Adolescent Psychiatry, a multidisciplinary team provided a Clinical Perspectives presentation on the screening, assessment, and treatment of sexually abused children. Topics included a review of the diagnosis and misdiagnosis of sexual behavior in children, evidence-based tools for screening and assessment of childhood sexual abuse, evidence-based approaches for treatment of childhood sexual abuse, indications and contraindications for eye-movement desensitization (EMDR), and the role of psychotropic medications.

Results

Defining problematic sexual behavior

Some sexual behaviors are developmentally appropriate. These behaviors are most often noted in children under the age of 6, occur more often at home than at school, and decline with age. Examples include exposure of genitalia, voyeurism, and self-stimulation. Normal sexual play is unplanned, intermittent, agreed to by both children, and merely curious in nature. Such sexual play involves children of similar ages, sizes, and developmental levels and is not accompanied by anger, fear, or strong anxiety. Problematic sexual behavior is characterized by sexual acts that occur frequently, take place between children of widely differing ages or abilities, involve coercion, force, or aggression of any kind, and are potentially harmful to self or others. Examples include imitation of adult intercourse, masturbation with objects, insertion of objects into the vagina or rectum, and/or oral-genital contact. The use of coercion in sexual behaviors and behaviors directed toward much younger children are of particular concern as greater than one-third of sexual offenses against children are committed by other youth. Problematic sexual behavior can be associated with a number of psychiatric conditions, including obsessive compulsive disorder, bipolar disorder, developmental disorders and other impulse control disorders [3, 4].

Assessing problematic sexual behavior

Assessing problematic sexual behavior must be a thorough and culturally sensitive process. First, clinicians should gather subjective information from children, caregivers, and appropriate informants regarding the nature of sexual behavior. It is important to understand not only what occurred, but also details on who was involved, who initiated the behavior, where the child got the idea for the behavior, and how all parties felt following the behavior. Further, caregiver response to the sexual behavior should be explored. In addition to information gathering, clinicians may also administer the Child Sexual Behavior Inventory (CBSI) to assess specific sexual behaviors and symptom severity. However, it is vital to be aware of the child's gender identity when using this measure as clinicians must avoid over pathologizing LGBTQIA+ youth. Other cultural considerations throughout assessment include family views on sexuality, sexual behavior modeling, and family adversity. Differentiating normative and problematic sexual behavior is only one aspect of a thorough assessment. Trauma screeners such as the Trauma Symptom Checklist for Children (TSCC) and Trauma Symptom Checklist for Young Children (TSCYC) provide a more complete picture of posttraumatic stress symptoms. Broadband measures of childhood behavior including the Child Behavior Checklist (CBCL) and the Behavior Assessment System for Children (BASC) may also give insight into other comorbid psychiatric conditions.

Treatment considerations

Thorough assessment is essential for matching children to appropriate forms of evidence-based psychotherapy and pharmacotherapy. Psychotherapeutic considerations include Cognitive Behavioral Therapy (CBT), Trauma- Focused Cognitive Behavioral Therapy (TF-CBT), and EMDR. CBT may be most appropriate when sexual behaviors are dangerous, increasing in severity, or present without a trauma history. CBT for problematic sexual behavior utilizes a strength-based framework to focus on teaching youth to implement appropriate behavior, make safe decisions, and develop healthy relationships. With a 98% success rate, CBT has been shown to be an effective way to prevent future problematic sexual behaviors. This approach may be most appropriate when problematic sexual behaviors are dangerous, increasing in severity, or present without a trauma history [5].

Similarly, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has demonstrated efficacy in decreasing PTSD symptoms with

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more than 80% of children seeing significant improvements. This brief treatment reduces avoidance of traumatic events through the creation of a trauma narrative and increases healthy parenting, adaptive coping skills, and helpful thinking patterns. TF-CBT can be modified to address problematic sexual behavior and may be most appropriate when posttraumatic stress symptoms are the predominant concern and when sexual behaviors are related to traumatic experiences. Finally, EMDR appears to be as effective as traditional CBT and may produce more rapid results with single-incident trauma. The trauma narrative is paired with bilateral stimulation, allowing children to attend to the past and the present simultaneously, process traumatic events, and store memories in an adaptive way. EMDR may be most appropriate when the child identifies a specific trauma event to target and when problematic sexual behaviors are secondary to posttraumatic stress symptoms. In summary, determining the best psychotherapeutic approach depends upon the nature of problematic sexual behavior, the predominant symptom presentation, and the presence of a traumatic event and/or posttraumatic stress symptoms. Other important considerations include legal and ethical issues, availability of trained providers, family preference, and family involvement.

Pharmacotherapy can play an adjunctive role in the treatment of childhood sexual abuse and problematic sexual behavior but is rarely the primary treatment modality. Specific symptoms associated with PTSD, such as sleep disturbances and nightmares can be responsive to pharmacological interventions such as prazosin. However, failure to recognize childhood sexual abuse can result in misdiagnosis and overuse of medications such as second-generation antipsychotics. This can be exacerbated by the widespread unavailability of evidence-based psychotherapy, which may cause families and providers to be more reliant on medication management. Child and adolescent psychiatrists must provide diagnostic clarification so that medication regimens can be used rationally [6]. The medications used should be directed to target symptoms consistent with the specific psychiatric diagnoses. It is important that medication regimens are reviewed regularly so that they can be simplified. Poly pharmacy should be avoided whenever possible.

Conclusions

Childhood sexual behavior is often normative and developmentally appropriate but can escalate to a problematic level and negatively affect youth without appropriate intervention. Such behaviors are not always associated with childhood sexual abuse and can occur in a variety of childhood psychiatric diagnoses. Given the complex and individualized nature of childhood sexual behavior, evidence-based treatment in a multidisciplinary setting is ideal. Thorough, culturally sensitive assessment should include information gathering as well as screening measures for sexual behavior, trauma, and broadband behavior. Such information will enable appropriate referrals to evidence-based psychotherapy and pharmacotherapy. Evidence-based psychotherapies include CBT, TF-CBT, and EMDR and pharmacotherapy can be useful in managing specific symptoms associated with PTSD or specific psychiatric comorbidities.

Misunderstanding and under recognition of childhood sexual abuse and childhood sexual behavior combined with limited availability of evidence-based treatments can result in an over-reliance on pharmacotherapy. Child and adolescent psychiatrists play a crucial role not only in the simplification and clarification of medication regimens in these children but also the coordination of and referral to evidence-based psychotherapy. Clinicians interested in learning more about childhood sexual abuse and childhood sexual behavior should reference the National Child Traumatic Stress Network (NCTSN.org), the American Association of Pediatrics (AAP.org), and the National Center on Sexual Behavior in Youth (NCSBY.org).

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