
Dee Norton
CHILD ADVOCACY CENTER

Serving Youth with Problematic Sexual Behaviors and Their Families in a CAC Setting

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Dee Norton Child Advocacy Center

- National Children's Alliance accredited Children's Advocacy Center.

- Total of 1,613 children seen in 2017.
  Male = 46%
  Female = 54%

- 1,181 children received Child and Adolescent Forensic Trauma Assessments (CAFTA).
  Disclosure of Abuse = 56%:
    Neglect (Exposure to DV & Substance Abuse) = 41%
    Physical Abuse = 30%
    Sexual Abuse = 13%
    Other = 14%

What is the first thing that comes to mind when you hear the terms:

Offender

Perpetrator

Predator

Juvenile Sex Offender

What is the first thing you think when you hear these terms:

Youth with Problematic Sexual Behaviors

Youth with Inappropriate Sexual Behaviors

Youth with Illegal Sexual Behaviors

Problematic Sexual Behaviors Defined:

Problematic Sexual Behaviors (PSBs) are defined as behaviors which are initiated by a child that involve sexual body parts and are considered developmentally inappropriate and/or potentially harmful to themselves or someone else (Silovsky & Bonner, 2003).

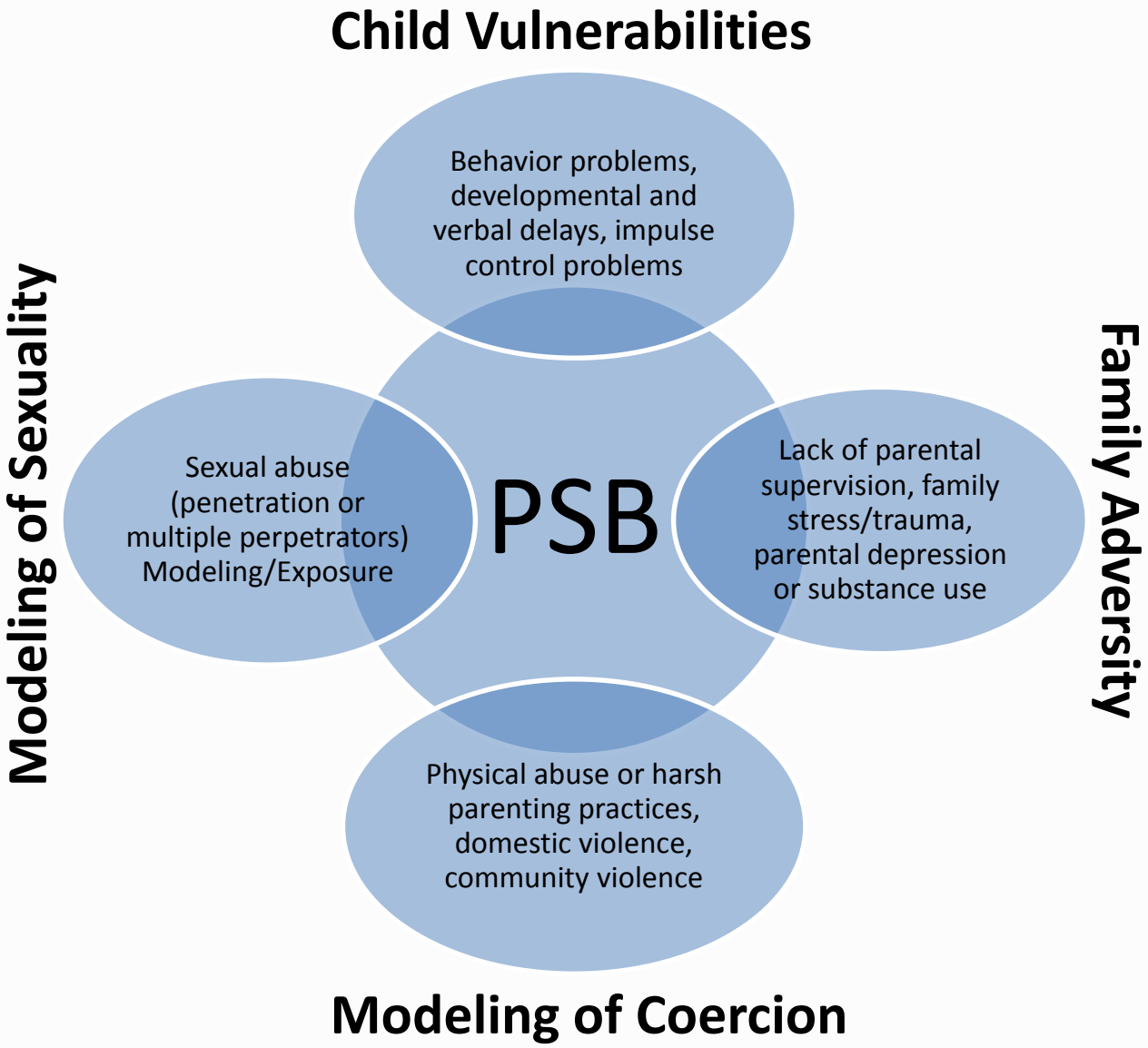
Sexual Development Begins Early

- Sexual development begins as early as infancy.
- Most children engage in self-touch behaviors as a means of self-soothing (Silovsky & Bonner, 2003; ATSA, 2006).
- Sexual play is a normal part of sexual development (Kaplan, et al., 2011). Sexual play is:
  - exploratory in nature.
  - spontaneous/intermittent.
  - occurs between children of similar ages/developmental levels.
  - mutually agreed upon.
  - not accompanied by fear or anger responses (ATSA, 2006).

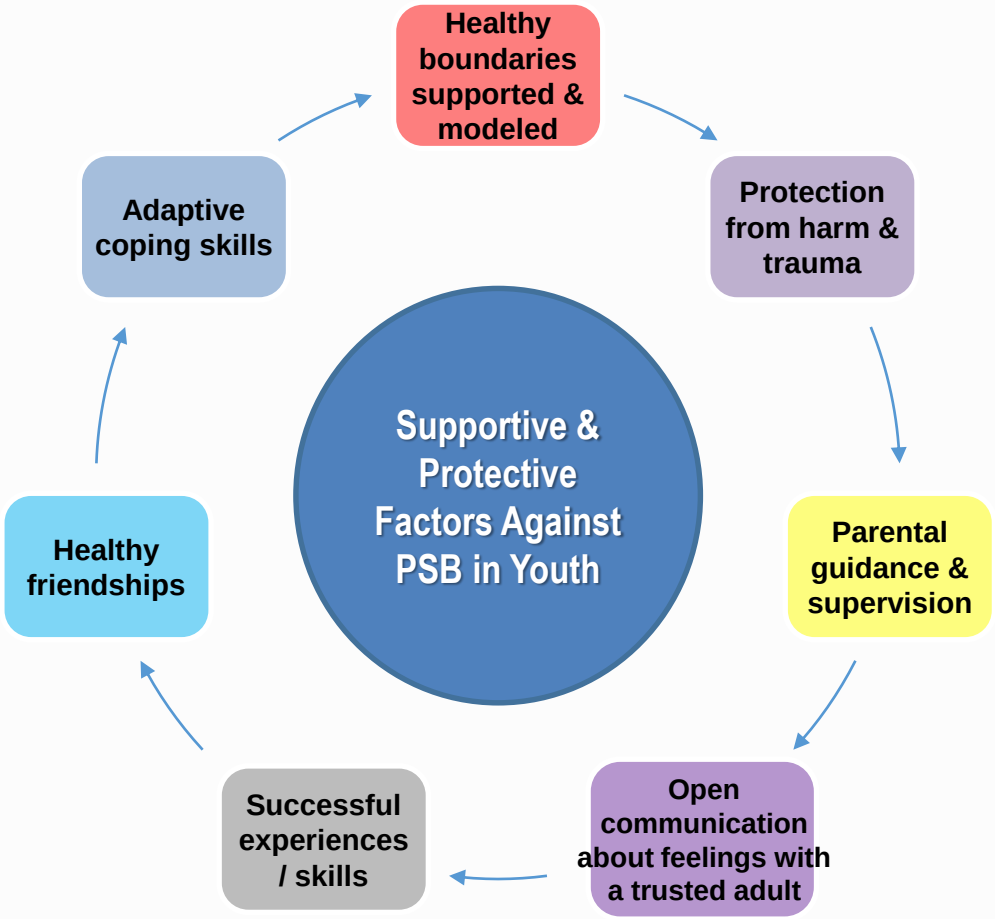
Determining if Sexual Behaviors are Inappropriate:

Frequency	Developmental Considerations	Harm
High Frequency	Occurs between Youth of Significantly Divergent Ages/Developmental Abilities	Intrusive Behaviors
Excludes Normal Childhood Activities	Behaviors are Longer in Duration than Developmentally Expected	Includes Force, Intimidation, and/or Coercion
Unresponsive (i.e., does not decrease) to Typical Parenting Strategies	Behavior Interferes with Social Development	Elicits Fear & Anxiety in Other Children

(Bonner, 1995; Davies, Glaser, & Kossoff, 2000; Friedrich, 1997; Johnson, 2004; Larsson & Svedin, 2001)



Adapted from Friedrich, Davis, et. al. 2003



Silovsky, 2015
OU-YPSB@ouhsc.edu

Age of Risk for ISBs:

Early adolescence is a high-risk, and to some extent transitory, developmental period for committing illegal sexual behaviors.

Silovsky, J., Brown, L., Ciesar, E., & Bray, C. (2016). Dispelling the Myths: Developing Fact-Based Policies and Practices to Address Problematic Sexual Behavior of Youth. National Child Traumatic Stress Network All Network Meeting.

Are Youth with ISBs Safe to be in the Community?

- With appropriate supervision, parenting strategies, and treatment, the majority of children and adolescents who have engaged in ISBs ***CAN*** live safely with other children and attend school (ATSA, 2006).
- There will likely be some changes in bathing, bathroom, and sleeping arrangements in order to maintain a safe environment.
- "Crime is more likely to occur when bonds with mainstream society are weakened – that is, when individuals lose or fail to develop social anchors such as
  - School involvement
  - Stable residence
  - Engagement in prosocial activities
  - Prosocial friendship networks
  - Committed relationships" Chaffin (2008).

Youth vs. Adults:

Youth:

- Difficulty reading social cues (Kaplan, et al., 2011)
- Socially rejected (Kaplan, et al., 2011)
- Lack impulse control and decision-making skills
- Peak of sexual development and puberty
- More likely to engage in PSB in a group, have a male victim, and have a victim under the age of 12 (Finkelhor, et. al (2009).
- Treatment tends to be more effective (Hanson, et al., 2009) with low recidivism rates between 2%-11% (ATSA, 2006)(Chaffin, 2008).

Adult:

- Charismatic and manipulative
- Gain the trust of youth and their caregivers easily
- Patient and goal-oriented
- Sexual attraction to youth and/or desire to show dominance over another individuals
- More often target teenage victims (Finkelhor, et. al (2009).
- Treatment tends to be less effective (Hanson, et al., 2009).

How Does this Population Align with the Population Local CACs Already Serve?

- In 20-25% of cases handled by Children's Advocacy Centers (CACs), youth or children under age 18 have acted out against another child.
- Research also shows that a similar proportion (23.2%) of sexual assaults are committed by juveniles.
- Therefore, a significant proportion of child sexual abuse cases encountered by CACs are likely to be committed by another child.
  - To achieve their goals of healing, justice, and prevention, CACs have an interest in addressing this issue and serving children and youth with problematic sexual behaviors (PSBs), their victims, and families.

1. National Children's Alliance 2015 statistical data submitted by Children's Advocacy Center members.
2. Howard N. Snyder, "Sexual Assault of Young Children as Reported to Law Enforcement: Victim, Incident, and Offender Characteristics" (Washington: Bureau of Justice Statistics, 2000), p. 8, retrieved December 8, 2016 from https://www.bjs.gov/content/pub/pdf/saycrle.pdf

CAC's Role in Working with Youth with PSB

- Given the etiology of these behaviors, these children are often already our clients
- CAC's are uniquely poised to meet caregivers with empathy and education
  - A compassionate response can directly improve engagement and possible outcomes for youth.
  - Improved coordination between victim provider and youth PSB provider
- MDT response
  - Education and dispelling of myths for MDT partners can improve outcomes for families
  - Responsibility for monitoring these cases can vary

NCA Standards

- Many CACs serve a vital role in their community by providing services to children with problematic sexual behaviors. CACs offering services to this population should have policies and procedures in place to maintain the physical and psychological safety for child victims and their families. This includes protected services times when child victims would not be at the center, separate entrances and waiting areas, or providing services through linkage agreements at off-site locations.

NCA Standards for Accredited Members, 2017 Edition.

Evidence-based Treatments for Youth with PSB

- Some researchers estimate that only 5% of juveniles with problematic sexual behaviors receive empirically supported treatments. (Henggeler & Schoenwald, 2011).
- A recent literature review found only 10 studies assessing treatment efficacy. (Dopp, Borduin, & Brown, 2015).
  - Of the 10 evaluated, 2 modalities were found to have the most robust results:
    - Multi-systemic Therapy
    - Cognitive Behavioral Therapy

Evidence-Based Treatments

- Treatment for youth with PSB – Qualities of effective treatment:
  - Must have strong behavior parent training and caregiver engagement
    - Relationship building, supervision, encouraging appropriate behavior, immediately address breaking rules including consequences
  - Appropriate peers
  - Decision making, self-control, laws and rules, boundaries
  - Sex education

  (St. Amand, Bard, Silovsky, 2008)

Treatments to Address PSB

- Evidence-based Interventions
  - Multi-systemic Therapy - info@mstservices.com
  - Problematic Sexual Behavior – Cognitive-Behavioral Therapy OU-YPSB@ouhsc.edu
  - Trauma-Focused Cognitive Behavioral Therapy [Treatment of Sexual Behavior Problems in Children] – tf-cbt@wpahs.org
  - Parent Child Interaction Therapy - pcit.international@gmail.com
- Webinars
  - National Children's Alliance sponsored:
    - Addressing Sexual Behavior in Trauma Treatment, http://www.nationalchildrensalliance.org/psb
  - Neari Press sponsored:
    - Assessment of Problematic Sexual Behavior in Children: What, When, and How, http://nearipress.org/event/assessment-of-problematic-sexual-behavior-in-children-what-when-and-how/

Multisystemic Therapy (MST):

- Currently only 5 randomized clinical trials exist related to treatment of adolescents with illegal sexual behaviors, 4 of which compare MST to “usual services.”
- These studies showed significant differences in rearrests between the MST group and the control for both sexual and nonsexual crimes.
- MST also showed reductions in general behavior problems, improved peer relationships, improved family relationships, and better grades.

(Henggeler & Borduin, 1990; Henggeler et. al, 2009; Borduin et. al, 2009; Letourneau et. al, 2009, 2013)

Focus of treatment

- MST is an intensive family and community based intervention (3+ sessions/week) targeted at reducing criminal behavior and out of home placements.
- MST-PSB is an adaptation of MST with the specific target of addressing PSB.
- Designed for youth 12-17
- Intervenes in all areas of youth's life: home, school, peers, family, and community
- Goal of empowering caregivers and changing youth's behavior in their natural environment
- Training is phased and involves the clinical team, organization, and community

Problematic Sexual Behavior – Cognitive-Behavioral Therapy (PSB-CBT)

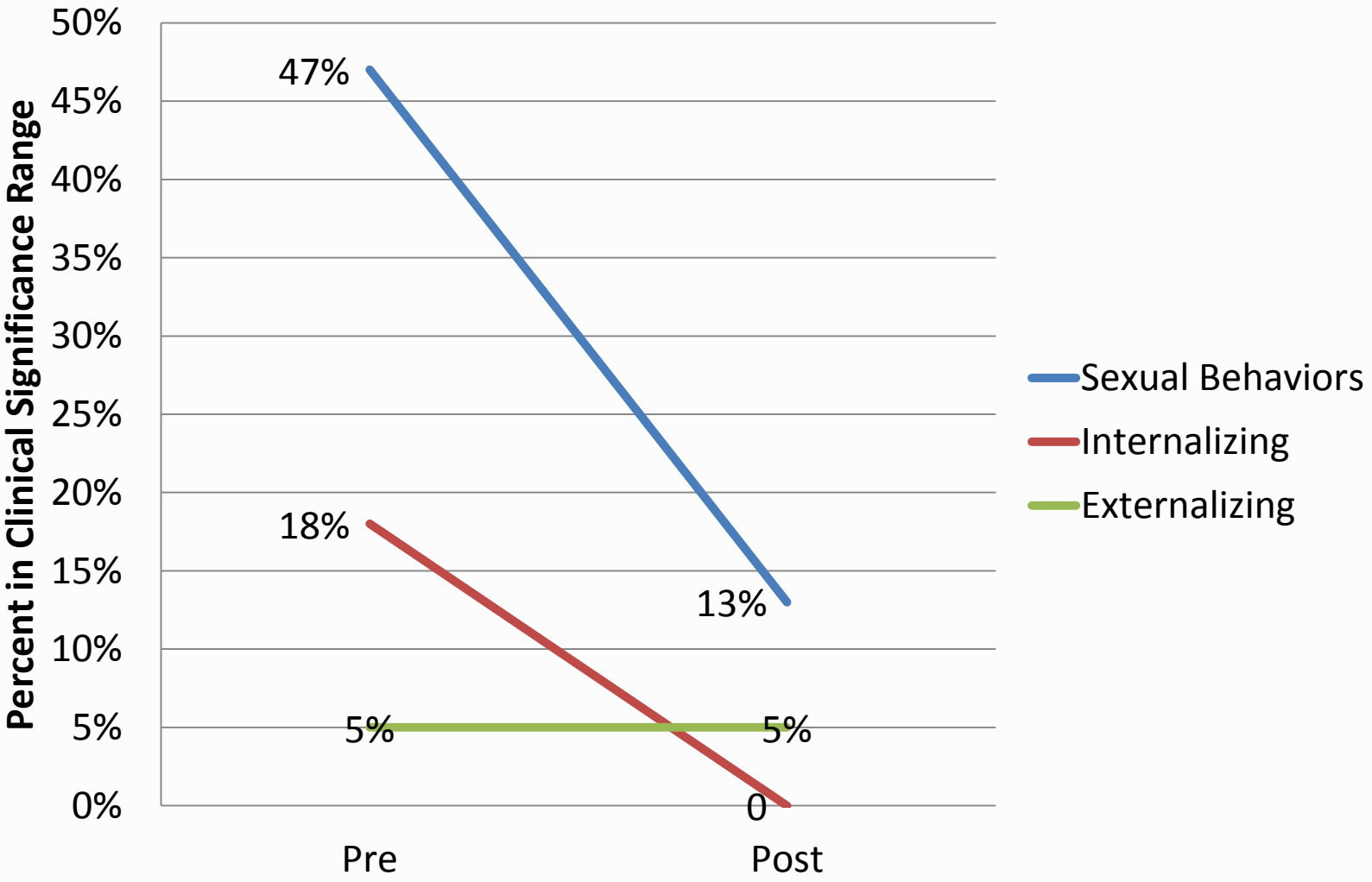
- The final randomized clinical trail evaluated PSB-CBT compared to treatment as usual and found PSB-CBT more effective in long-term recidivism rates. (Carpenter, et. al, 2006)
- The active ingredients within the treatment model:
  - **Behavior Parent Training**
    - Clear rule setting related to sexual behaviors and boundaries
    - Supervision
    - Positive parenting skills
  - **Sex education**
  - **Abuse Prevention**
  - **Self-control Skills**

Carpentier, M., Silovsky, J. F., & Chaffin, M. (2006).

Focus of Treatment:

- The primary focus of treatment is to eliminate the identified PSB.
- Other goals include:
  - improving the parent-child relationship;
  - reducing non-sexual problematic behaviors;
  - improving school behavior;
  - and, generally improving behavior at home and in the community.
- Training:
  - A manual exists for this intervention
  - In person training is phased and includes the clinical team, the organization, and community partners as well as follow-up consultation

Treatment Outcomes



Trauma-Focused Cognitive Behavioral Therapy [Treatment of Sexual Behavior Problems in Children]

- Grounded in the principles of gradual exposure
- Primarily focused on reducing PTS symptoms; Also can improve symptoms of depression, anxiety and externalizing behavior problems
- Work with the caregiver is focused on improving their capacity to support their child through improved communication and positive parenting practices
- Training
  - A printed manual as well as online courses are available for training
  - National Certification requires didactic training, phone consultation, and successful completion of an exam

Cohen, J. A., & Mannarino, A. P. (1996); Cohen, J. A., & Mannarino, A. P. (1997); Stauffer, L. B. & Deblinger, E. (1996); Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004); Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011).

Focus of Treatment

- 12-18 1-1.5 hour sessions conducted weekly with the child and a supportive caregiver
- Treatment elements follow the acronym PRACTICE:
  - Psycho-education & Parenting
  - Relaxation
  - Affective Identification and Regulation
  - Cognitive Coping
  - Trauma Narration & Processing
  - In-vivo Mastery
  - Conjoint Sessions
  - Enhancing Safety & Future Development

https://tfcbt2.musc.edu/

Parent-Child Interaction Therapy

- Dyadic intervention focused on addressing behavior problems in children 2-7 years old
- Primary focus is reducing externalizing behaviors in children and building caregiver's capacity to utilize positive parenting practices
- Can also have an impact on internalizing behaviors in youth; build caregiver's understanding of child development, improve caregiver and child relationship
- Training:
  - A manual describes how to implement this program
  - Training includes 5 day in-person training as well as follow-up consultation and completion of 2 cases

Shuhman, E. M., Foote, R. C., Eyberg, S. M., Boggs, S., & Algina, J. (1998); Nixon, R. D. V., Sweeney, L., Erickson, D. B., & Touyz, S. W. (2003); Chaffin, et. al. (2004); Bagner, D. M., & Eyberg, S. M. (2007).

Focus of Treatment

- Treatment averages 14 sessions but is based on the client's successful mastery of skills
- Occurs in 2 phases
  - Child Directed Intervention (CDI)
    - Caregivers demonstrate skills related to praise, reflection, descriptors, etc.
  - Parent Directed Intervention (PDI)
    - Caregiver effectively communicates instructions and commands
    - Caregiver corrects disruptive behaviors in child with the support of therapist coaching

www.pcit.org

Resources

- National Center on the Sexual Behavior of Youth
  - http://www.ncsby.org/
  - Provides fact sheets, guidelines for clinical decision making and resources for professionals and families
- The National Child Traumatic Stress Network
  - www.nctsn.org
  - Provides information about trauma for parents, caregivers, and professionals
  - Facts sheets available about youth with PSB made in collaboration with NCSBY
- National Children's Alliance
  - http://www.nationalchildrensalliance.org/psb
  - Fact sheets, video training series, and information for caregivers

Resources cont.

- Association for the Treatment of Sexual Abusers
  - http://www.atsa.com/
  - Access to their Journal, and recently published Practice Guidelines for Assessment, Treatment, and Intervention for Adolescents
- California Clearinghouse of Evidence-Based Treatment for Child Welfare
  - www.cebc4cw.org
  - Provides child welfare professionals with access to information about selected child welfare related programs.
  - Provides systematic method for evaluating intervention models based on research and scientific veracity

Questions, Comments, Concerns?