



Children with Problematic Sexual Behavior: Recommendations for the Multidisciplinary Team and Children's Advocacy Center Response

Jerri Sites, MA
Southern Regional Children's Advocacy Center

Jimmy Widdifield, Jr., LPC
Oklahoma Commission on Children and Youth

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Jane Silovsky, PhD

Director, Center on Child Abuse and Neglect

University of Oklahoma Health Sciences Center, Oklahoma City, OK

Carrie Jenkins, LPS/S

Clinical/Forensic Services Team Supervisor

Sub-Specialty Leader, Sexual Behavior Problem Program

Dee Norton Child Advocacy Center, Charleston, SC

Michelle Miller

Project Director, Mental Health Initiatives

National Children's Alliance, Washington, DC

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ABSTRACT

Cases of children ages 12 and younger with problematic sexual behavior (PSB) can present a myriad of challenges for multidisciplinary teams (MDTs) and Children's Advocacy Centers (CACs). After all, MDTs and CACs were historically designed to address maltreatment of children committed by adults, not by other children. When presented with child-initiated harm cases, child-serving agencies are often inadequately equipped to provide the integrated and comprehensive response that is required in these situations. Significant disparities exist across many communities regarding resources specifically geared toward the initial response and assessment of cases of children with reported PSB; development and implementation of MDT and CAC protocols specific to these cases; and treatment options for the children involved and their caregivers. Further, many professionals do not have foundational or current knowledge of the research and best practices related to children with PSB, hindering quality decision-making. Child-serving professionals, however, can become more effective in responding to and managing cases of children with PSB. This can be accomplished through training on the nature of normative and problematic sexual behaviors in children; employing engagement strategies for children and families; focusing on long-term outcomes for children with PSB, in an effort to reduce the risk of PSB from reoccurring; and revising policies and procedures to reflect best practices to meet the needs of all children served. Together, the MDT approach and the CAC model are ideal vehicles for the provision of the resources needed for the development and implementation of an integrated and comprehensive systems approach to cases of children with PSB and their families. This white paper will focus on how cases of children ages 12 and younger who initiate PSB, the child victim(s), and their families could be successfully served by CACs and MDTs.

INTRODUCTION

The literature on children with PSB commonly defines *children* with problematic sexual behaviors (PSB) as “children ages 12 and younger who *initiate behaviors involving sexual body parts* (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others (Chaffin et al., 2008; NCTSN, 2009; Silovsky & Bonner, 2003). The origins of these behaviors range from curiosity, imitation, attention-seeking, impact of adversity and trauma, and/or other reasons (Chaffin et al., 2008; Friedrich, 2006; Lussier, Chouinard, McCuish, Nadeau, & Lacerte, 2019; Silovsky & Bonner, 2003). Regardless, research suggests that the vast majority of children will not persist with PSB into adolescence and adulthood (Carpentier, Silovsky, & Chaffin, 2006; Cohen & Mannarino, 1997; Silovsky, Niec, Bard, & Hecht, 2007; Silovsky, Hunter, & Taylor, 2018), particularly if caregivers are actively involved in treatment services (St. Amand, Bard, & Silovsky, 2008).

The multidisciplinary team (MDT) and Children’s Advocacy Center (CAC) model approaches are an ideal vehicle for a community approach to intervene and provide services to children and families impacted by PSB. CACs were originally designed to address maltreatment of children by adults and brought together all the systems needed to successfully do the work in a way to reduce additional adversity/trauma to the child and increase safety of children. Over time, though, CACs evolved to provide more comprehensive services to a broader group of youth, including PSB initiated by youth. Today, many CACs and MDTs are well-suited to address the needs of children with PSB given their child-focused setting, array of services, and collaborative relationships with system and community partners. Cases of adolescents who initiate PSB are typically managed by the local juvenile justice system, not the CAC or MDT. However, many juvenile justice systems partner with local CACs and collaborate with the MDT to provide the most comprehensive services possible to adolescents who initiate PSB, their child victims, and their families. It is the spirit and manifestation of collaboration for the good of all youth involved that produces the most successful outcomes for youth—be they children or adolescents.

The potential for the CAC and MDT approaches for cases of children with PSB is not yet realized nationwide. This fact is evident from the data collected from the “Survey on Youth with Problematic Sexual Behaviors,” conducted by the National Children’s Alliance (NCA), the member accreditation organization for CACs. Released in November 2019, the survey identifies perspectives from CAC programs across the United States on the CAC and MDT approaches to PSB. The survey encompasses CAC perspectives on youth with PSB (ages 17 and younger) and was provided to all NCA member CACs (N=893), of which 351 responded. According to the survey, cases of youth with PSB are handled differently from community to community across the United States. Results indicated that 35.3% of respondents reported their communities do not have a structured or consistent response to children with PSB. However, 47% reported

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that most professionals respond with a rehabilitative approach, that is, by maintaining treatment as the primary focus for most youth with PSB. The survey indicates that common misconceptions of youth with PSB exist among child-serving professionals in the community. For instance, 73.5% of those surveyed believe that most or all adolescents with PSB have been sexually abused, and 67.8% believe that adolescents are perceived as similar to adult sexual offenders. Thus, it can be concluded

that the majority of child-serving professionals are unaware of the research and best practices related to cases of youth with PSB.

In communities where misconceptions of PSB are prevalent, child-serving professionals likely have not received relevant training on children with PSB. Counter to the myth that all children with PSB have been sexually abused, research demonstrates more complex origins and that many children with PSB are not victims of child sexual abuse (Chaffin et al., 2008; Silovsky & Niec, 2002; Allen, 2017). Without this knowledge, in many cases, professionals often attempt to forensically interview the children involved regarding potential child sexual abuse. Recent research also shows that children with PSB can remain in their communities and are highly responsive to appropriate treatment that actively involves caregivers (Carpentier et al., 2006; Chaffin et al., 2008; Silovsky et al., 2018; St. Amand et al., 2008). Unfortunately, oftentimes, children are removed from their homes, placed in residential facilities or detention, and do not receive treatment that involves their caregivers. When professionals (and the general public) are not versed on the current research or lack appropriate training, children and their caregivers will likely be adversely impacted by those who are in a position to help them address the issue.

Caregivers of a child with PSB experience a range of responses to their child's behavior and typically do not know where to access support (Shields et al., 2018). Many communities do not have identified treatment providers or programs that specialize in children with PSB. It is critical for families to have access to professionals who are trained to provide individualized case management, including safety planning and identifying potential treatment needs of the children involved. Additionally, the development of an MDT protocol for children with PSB can ensure that a child- and family-focused, collaborative response can be provided.

Without a written protocol that outlines a clear process for handling cases involving children with PSB, there is a high level of uncertainty among child protection and criminal justice professionals on how to respond. Typically, when a report is made of a child initiating alleged PSB, law enforcement assumes the lead in conducting an investigation to determine whether a crime was committed. The law enforcement investigation may trigger coordination with child protective services (CPS) and, potentially, the juvenile justice system. However, cases involving children with PSB, ages 12 and younger (often referred to as, "child-on-child"), are typically reported to CPS, who may become involved if there is concern that a primary caregiver has engaged in neglect (e.g., inadequate supervision) or abuse (e.g., sexual), which will likely result in a referral to law enforcement. Regardless, if policies dictate involvement only when there has been neglect or abuse by a caregiver or a potential crime has been committed by a juvenile or adult, then cases that do not meet these criteria will likely "fall through the cracks." This results in no response, no engagement of involved children and their families in meaningful and helpful ways, and limited options for treatment or support for all involved.

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Furthermore, in the absence of a specific protocol for PSB cases, investigators tend to default to what they know: investigating allegations as if the PSB was a reported crime committed by an adult. In such cases, this process typically begins with law enforcement and CPS sharing with one another available case information

then scheduling the “alleged victim” child for a forensic interview. Based on the information obtained in the forensic interview, the investigators attempt to gather additional facts and corroborative evidence from other sources, and will eventually conduct an interview (either forensic or investigative) of the child who initiated the sexual behavior, often labeling the child as the “alleged perpetrator.” This response is not developmentally appropriate and in itself may negatively impact the quality and outcome of the investigation and management of the case. This, in turn, can adversely impact the child who initiated the sexual behavior and their family’s willingness to engage with the system, increasing the chance that they will not receive needed support and treatment services.

To achieve the shared goal of providing effective support and treatment services to children with PSB, their child victims, and their caregivers, it is imperative that a comprehensive, collaborative, child- and family-focused MDT response be employed. This effort will likely reduce the risk of the PSB from reoccurring and promote healthy behaviors. This type of response will also increase the likelihood of family engagement in every step of the process and allow professionals to partner with caregivers to determine what course of action to take.

DEVELOPING AN INTEGRATED RESPONSE TO PSB: TRAINING AND EDUCATING CHILD-SERVING PROFESSIONALS

Training for child abuse professionals is paramount in creating, cultivating, and sustaining stakeholder and MDT engagement for developing and providing an evidence-informed integrated response to children with PSB and their families. Typically, initial trainings include overview presentations of a variety of topics and on-going follow-up to reinforce concepts and provide additional focused training and consultation. General training topics for professionals who may come into contact with cases involving a child with PSB should include:

- Child sexual development.
- Defining problematic sexual behavior in children.
- Understanding factors that may contribute to and prevent PSB.
- Impact of PSB on families and other children (e.g., the victim), review and dispel common myths attributed to children with PSB.
- Basic safety planning in homes and other environments.
- Characteristics of effective treatment and qualified licensed mental health practitioners.
- Accessing local and national resources.

NCA, in collaboration with the National Center on the Sexual Behavior of Youth and the Midwest Regional Children’s Advocacy Center, created online training modules focusing on children with PSB, which provide an overview of key information across these topics. These modules are designed for MDTs and community stakeholders, such as CACs, CPS, law enforcement, juvenile justice, prosecutors, schools, daycares, and other child-serving organizations. The modules not only offer a better understanding of

children with PSB, but also promote establishing an organized and integrated response to these cases. NCA also has available fact sheets designed for CAC leadership and staff, MDTs and their partners, parents and caregivers, and mental health professionals, as well as a best practices overview document to support the development of processes and forms for providing PSB treatment and services through a CAC. Within all of these resources, NCA promotes the CAC model and MDT approach for cases involving children with PSB. According to NCA Executive Director Teresa Huizar, “When responding to kids with problematic sexual behaviors, CACs are the absolutely crucial link between how communities address the problems and the science on what works” (NCA, 2016). The training modules, fact sheets, and best practice overview documents are available on the NCA website: <https://learn.nationalchildrensalliance.org/psb>. Direct links to those items are provided in resource section of this paper.

ADAPTING THE MDT APPROACH AND CAC MODEL TO PSB CASES

The CAC model is an ideal and multifaceted resource for child abuse professionals that can be adapted to help organize and develop a more effective and integrated response to children with PSB and their families. In 2020, NCA reported 901 member CACs in the United States. Further, the *multidisciplinary team* component within the CAC model requires a written interagency agreement signed by authorized representatives of MDT member agencies that confirms their commitment to participating and supporting the MDT approach through cooperation and collaboration with all MDT members in the intervention of child abuse. MDTs are multi-layered, therefore, it is important that along with frontline professionals, their supervisors, and senior leaders (e.g., people with authority to make changes, such as agency directors) should be an integral part of this process. Written protocols outlining the MDT response should be developed with the input of all MDT member agencies and should be reviewed and updated at least every three years. Any revisions to the protocol should be reviewed by frontline professionals who work child abuse cases, their supervisors, and senior leaders. Interagency agreements and protocols provide mechanisms within the CAC model, or in standalone MDTs, that can be readily adapted to address cases involving children with alleged PSB and can be executed as a revision or addendum to existing protocols. Some communities have developed task forces or workgroups to provide a separate response to cases of children with PSB that are loosely or unaffiliated with a CAC and/or MDT. Others have rolled these cases into their existing CAC/

MDT response protocols. A list of PSB programs that are available for consultation is available in the “Resources” section of this paper. Regardless of access to the services of a CAC, MDT protocols specific to cases of children with PSB are necessary for a well-informed, comprehensive response. However, communities that have access to a CAC benefit from having a structure already in place conducive to providing necessary supports and resources for families and professionals, which can be adapted to address cases of PSB.

In recent years, CACs have seen an increase in reports and referrals for services for children with alleged PSB, and many professionals believe the CAC/MDT model provides a compatible framework to address these cases.

Accredited CACs are required to meet ten NCA member accreditation standards. These standards for operation have evolved over time and require revision as more research becomes available and informs best practices. Although the current standards are not fully inclusive of cases of children with PSB, they do not prohibit CACs from serving this population. In recent years, CACs have seen an increase in reports and referrals for services for children with alleged PSB, and many professionals believe the CAC/MDT model provides a compatible framework to address these cases. Thus, it makes good sense for communities that have access to CAC services to explore adapting the NCA Standards for Accreditation to accommodate their needs. Following are the ten NCA Standards for Accreditation (NCA, 2017) along with how each one may be adapted to address youth with PSB cases:

ADAPTATION OF NCA STANDARDS FOR PSB CASES

NCA Standard for Accreditation

Adaptation to PSB Cases

Multidisciplinary Team—A multidisciplinary team for response to child abuse allegations includes representation from the following: law enforcement, CPS, prosecution, medical, mental health, victim advocacy, and the CAC.

These are the necessary disciplines to intervene in cases of children with PSB. Additional disciplines or agencies include, but are not limited to, schools, juvenile justice, and family court.

Cultural Competency and Diversity—The CAC provides culturally competent services for all CAC clients throughout the duration of the case.

The very nature of this standard addresses the concern of misinformed or unintentionally biased professionals who may approach cases involving children with PSB in a developmentally inappropriate, punitive, and/or non-child/family-focused manner.

Forensic Interviews—Forensic interviews are coordinated to avoid duplicative interviewing and are conducted in a manner that is legally sound and of a neutral, fact-finding nature.

Although not all cases of children with PSB will warrant a forensic interview of the alleged victim, CAC forensic interviewers are required to be trained in and practice a nationally recognized forensic interview model. These models can be adapted for use with children with PSB. NCA has recently formed a collaborative workgroup to create guidelines for forensic interviews of children involved in PSB.

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NCA Standard for Accreditation

Adaptation to PSB Cases

Victim Support and Advocacy—Victim support and advocacy services are provided to all CAC clients and their caregivers as part of the multidisciplinary team response.

In recent years, this standard has become more robust and incorporates a variety of supportive processes provided by CAC victim and family advocates. Beyond making referrals for additional services, the advocates' continued involvement with families provides the ongoing support families need for sustained engagement with the system, which is critical in providing an effective response to cases of children with PSB.

Medical Evaluation—Specialized medical evaluation and treatment services are available to all CAC clients and are coordinated as part of the multidisciplinary team response.

If there is a need for medical evaluations in cases of children with PSB, then those evaluations should be conducted by highly trained medical providers who have a clear understanding of the effects of child abuse. This resource already exists in the CAC model. The added benefit is that these providers also serve as an integral part of the MDT.

Mental Health—Evidence-based, trauma-focused mental health services, designed to meet the unique needs of the children and caregivers, are consistently available as part of the multidisciplinary team response.

The mental health component is critical in evaluating cases involving children with PSB. Trained licensed mental health practitioners should be available to the MDT for provision of expert consultation on children with PSB, especially when the team is conceptualizing the case and subsequent response and plan, determining next steps, and recommending treatment options for children with PSB, child victims, and their caregivers.

Case Review—A formal process in which multidisciplinary discussion and information sharing regarding the investigation, case status, and services needed by the child and family must occur on a routine basis.

Case review is necessary for cases of children with PSB to ensure continued engagement with the family, that services are in place for all involved, and for the MDT to remain informed about the progress of the child with PSB and their family. It also serves as a means for accountability of MDT members involved in the case and celebrating successful interventions. Depending on the volume of children with PSB cases in a community, PSB case reviews can be held separately or included in the regularly scheduled meetings facilitated by the CAC.

Case Tracking—CACs must develop and implement a system for monitoring case progress and tracking case outcomes for all multidisciplinary team components.

Case tracking can be beneficial for PSB cases as well, not only to monitor cases, but to also collect data that can be used to promote changes in responses by the MDT as well as the community.

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Organizational Capacity—A designated legal entity responsible for program and fiscal operations has been established and implements basic sound administrative policies and procedures.

Whether the CAC is a standalone non-profit, a program within an umbrella agency, or part of a governmental entity, the CAC model has policies and procedures in place to provide guidance on how to provide services for families and children in cases of child maltreatment, which can include cases of children with PSB.

Child-Focused Setting—The child-focused setting is comfortable, private, and both physically and psychologically safe for diverse populations of children and their family members.

Although the CAC/MDT model can be easily adapted to accommodate reports of children with PSB, there has been some debate in the CAC movement regarding maintaining the NCA accreditation standard for a child-focused setting when providing services to children with PSB. NCA (2016) has clarified the standard to promote the CAC model for cases of youth with PSB:

“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 physical and psychological safety for child victims and their families. This includes protected service 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.”

More specifically, NCA provides guidance for practice approaches to meet the Child-Focused Setting Standard in cases in which juveniles with PSB are in need of services:

“Additional policies address situations when juveniles with problematic sexual behaviors are in need of a victim interview at the CAC, and when sexually reactive children are receiving other services at the CAC. Separation is achieved by scheduling their appointments when there are no other children in the building; when they do not come in contact with the potential child victim in the case; when they are supervised at all times; and/or are escorted directly to interview or therapy rooms where they do not have contact with other children in the waiting room” (NCA, “Putting Standards into Practice,” 2016, p. 104).

Developing an MDT Protocol for Cases of Children with Alleged PSB

Regardless of whether a community has access to the services of a CAC, it is important that the response to cases of children with PSB also include representatives from MDT member agencies, as well as juvenile justice, schools (e.g., school liaison or counselor, and/or school resource officers), and family court personnel. As part of this response, it is crucial that each agency be included in the process of creating the protocol and an interagency agreement specific to cases of children with PSB, which should be signed by authorized representatives of each agency and meet state and local guidelines for sharing confidential information.

The role of each agency in these cases should be clearly identified and explained within the protocol. The

As part of this response, it is crucial that each agency be included in the process of creating the protocol and an interagency agreement specific to cases of children with PSB.

NCA “Youth with Problematic Behavior: Best Practice Documents Overview” resource document provides sample documents for the MDT response, case review, confidentiality, home safety plans, MOUs, and treatment services, along with recommendations for their use. A direct link to this document is available in the “Resources” section of this paper. This resource provides the necessary framework for communities to create their own response protocols and to develop treatment options based on their capacity and needs.

Engaging Families

Applying the MDT approach and CAC model to cases of children with PSB is critical to the engagement of families, which is a key factor in helping the child cease the PSB. Since there is potential for several members of the MDT and/or CAC to interact with the child with PSB and their caregiver, a child- and family-focused approach will significantly improve the likelihood of family engagement collectively with all professionals and systems involved. Further, maintaining a developmentally appropriate approach promotes the mission of protecting children, enhances the levels of trust between the MDT, CAC and families, and thereby increasing the potential for continued engagement of families during the investigation process and, if needed, treatment services.

The use of people-first language in verbal and written communication and materials is paramount when approaching anyone, especially families with children with PSB. Children with alleged PSB are children first and tend to respond positively to intervention. Professionals should use terms such as “children with problematic sexual behavior” instead of misattributions such as “perpetrator” or “offender,” which can result in unintended negative consequences regarding the case (Harris & Socia, 2016; Letourneau, Schoenwald, & Sheidow, 2004). The latter terms are borrowed from the adult justice system and infer more adult-like characteristics, which are inappropriate to apply to children. Further, use of these terms with youth with illegal sexual behavior has been shown to hinder achievement of successful outcomes (Harris & Socia, 2016). While it is important to note that the term “adolescent sex *offender*” is the ingrained and most widely used term across systems for youth ages 13 and older, it, nor any derivative of the term, is appropriate to apply to children due to significant differences between the development of children and adolescents and the dynamics of their sexual behaviors. Using people-first language is a simple, yet powerful, tool to engage families and support desired outcomes for children.

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Frequent and non-judgmental communication is another important tool for engaging caregivers of children with PSB. When a case of a child with suspected PSB is referred to a CAC or MDT, contact with the caregiver should happen as quickly as possible, at least within 48 hours. The sooner a professional connects with the caregiver, the sooner the family receives the emotional and logistical support needed to successfully navigate their entry into and out of child-serving systems. First responders, such as law enforcement, CPS, and/or family advocates, set the tone for the family's experience with child-serving systems. Using knowledge obtained through training, professionals should easily be able to convey both the seriousness of the child's reported sexual behavior and a sense of hope for a positive outcome for the child and family without casting blame or judgement. As families proceed with the CAC and/or MDT, they should receive ongoing communication that is coordinated across the professionals and agencies involved so they can better collaborate and engage in services.

Assessing Children with PSB

In the initial stage of the investigation of cases involving allegations of children with PSB, it is important that the MDT members assigned to the case (typically law enforcement and/or CPS) come together to share case information and determine next steps. In addition to the investigator(s) assigned, this team should always include a mental health provider who has a clear understanding of child development, sexual behaviors (normal vs. problematic, harmful, and illegal), childhood adversities, treatment options, diagnosis, and supervision. In these cases, information gathered from collateral witnesses is crucial in determining next steps. Approaching the children's caregivers in a supportive manner to gain insight on any concerns they may have can be an excellent resource for the investigation. When assessing these cases, it is the team's responsibility to explore adversities in both children's lives beyond the reported sexual behaviors.

In addition to the investigator(s) assigned, this team should always include a mental health provider who has a clear understanding of child development, sexual behaviors (normal vs. problematic, harmful, and illegal), childhood adversities, treatment options, diagnosis, and supervision.

The use of forensic interviews in cases of children with suspected PSB should not be automatic, but rather an informed recommendation of the team assigned to the case. If, based on the allegations a potential crime has been committed, a forensic interview of the alleged victim would be in order early on in the investigation. MDTs should keep in mind that, to date, there is no nationally recognized forensic interview model for cases involving children with PSB. In the absence of such a model, and if the MDT deems it necessary for a forensic interview to occur, the forensic interviewer should be trained in a nationally recognized forensic interview model and follow those standards of practice. When conducting the

forensic interview of the recipient child (i.e., "victim"), the circumstances of the PSB should be explored while avoiding any assumptions that the child may or may not have a history of child sexual abuse. If the child who is reported to have initiated the sexual contact is forensically interviewed, then the forensic interviewer should follow the same model, and in addition, redirect the child in the interview if they begin to share exculpatory details of their behaviors.

When the investigative MDT determines that the referred child's sexual behavior is significant, a trained mental health provider should conduct a clinical assessment of the child with PSB to determine treatment needs and inform safety planning. Once the clinical assessment is completed, the assigned MDT should meet with the mental health provider and engage in collaborative decision-making to determine recommendations for treatment services and safety planning for all children involved, including considerations for increased supervision or placement of the child who initiated the sexual behavior.

It is important for MDTs to follow PSB cases from the initial intervention, through case review and ongoing case management. MDTs typically engage in case review at a minimum of a monthly basis. These cases should be followed through completion of treatment services, which will allow the team to track the progress of the families involved, monitor any concerning issues related to safety and supervision, and provide support as needed. Case review, as well as case tracking, are components of the NCA Standards for Member Accreditation for CACs. If the MDT has access to a CAC, this structure will be in place and can serve as a means to track the progress of families involved in cases of PSB.

Providing Treatment and Support to Children with PSB and Their Families

When it has been determined that a child with PSB requires clinical services, or treatment, it is the point person on the MDT and/or at the CAC's role to help guide the families to these services. Therefore, it is essential that the MDT/CAC be as knowledgeable as possible regarding the qualifications and experience required of mental health providers to provide treatment for PSB. Providers should have a Master's degree or higher in a clinical or counseling discipline and be licensed within the state to provide mental health services. Many agencies employ graduate students and/or new graduates pursuing licensure as therapists, who may be appropriate to provide clinical services if they have received evidence-based training and are under the direct supervision of a licensed mental health professional. These practitioners should have experience and education on child development; sexual development; childhood adversity and trauma; common childhood mental health disorders; differential and co-morbid diagnoses; PSB in children; evidence-based treatments for common childhood mental health disorders and, preferably, PSB; effective parenting strategies and child behavior management; and safety planning. Mental health providers who work with children and families typically have most of these qualities, though many are not educated or experienced in treating children with PSB. Mental health providers trained in evidence-based treatments for child trauma (e.g., Trauma-Focused Cognitive-Behavioral Therapy) may be suitable providers given their experience with addressing sexual issues (i.e., child sexual abuse). These providers, if not trained on PSB in children, should seek appropriate consultation from a fully qualified provider. The University of Oklahoma Health Sciences Center has developed an extensive, evidence-based PSB Cognitive Behavioral Therapy training program for mental health providers, as well as advanced training for those certified in Trauma-Focused Cognitive-Behavioral Therapy. A link to the program ("Training Resources") is available in the "Resources" section of this paper. It should be noted that availability for training in these models is very limited.

The first step to address behavioral health needs of children is to administer a clinical assessment. It is important to note that children benefit the most from a clinical assessment and not a psychosexual

evaluation. The latter is typical for adults with illegal sexual behavior as the evaluation focuses on sexual interests, attitudes, behaviors, and functioning, typically toward children, in an effort to determine the risk of the adult re-engaging in illegal sexual behavior. Psychosexual evaluations are not developmentally appropriate for children, nor helpful due to the etiology of PSB in children. Because clinical assessments are not forensic in nature, scheduling them post-investigation reduces the chance of interference with the investigative response and unintended adverse consequences for the child and family.

The goal of a clinical assessment for a child with PSB is three-fold: to evaluate the sexual behaviors on a continuum of normative to problematic; to identify other developmental and mental health and practical needs that may be contributing to the PSB; and to inform treatment recommendations. There are times, after the assessment, that it is determined that the sexual behaviors are normative and preventative measures including education are recommended instead of therapeutic intervention. In cases in which children are recommended to receive treatment, clinical assessment is provided on an ongoing basis to monitor progress toward treatment goals. The results of clinical assessments allow for the MDT to more accurately conceptualize the case and better gauge the level of their response and duration of involvement with the family.

Treatment for children with PSB is informed by the clinical assessment. Results will indicate if the PSB is a single concern or part of a constellation of symptoms associated with trauma, disruptive behavior disorders, or something else altogether (e.g., developmental delay or disorder). The type of treatment most appropriate for the child will depend on these results. For example, if the PSB is a single concern, then PSB-focused treatment is warranted as opposed to trauma treatment that would focus on addressing trauma symptoms and secondarily the PSB. Cases in which there are significant disruptive behaviors other than PSB (e.g., behaviors that threaten safety and warrant placement) may require those concerns be addressed first for stabilization purposes, which will then facilitate the delivery of treatment of the PSB.

Treatment is typically short-term (3–6 months) and should be provided in the least restrictive environment, which is commonly community-based. Most children with PSB do not require intensive inpatient or residential treatment unless the child is actively suicidal, homicidal, or experiencing significant psychosis, or otherwise cannot remain safely in the community.

Effective treatments for children, including children with PSB, actively involve the caregiver(s) in sessions. Because PSB in children is a behavior problem, caregivers are the primary agent of change for children's behaviors since they have the most contact with the child and are responsible for raising the child. Research clearly indicates that effective treatment for reducing or eliminating PSB in children requires caregivers to participate in sessions and receive information and support on enhancing parenting skills associated with effective behavior management with a focus on targeting the PSB. At a minimum, this includes providing psychoeducation on child development, sexual and otherwise; strengthening the caregiver–child relationship; and developing and implementing clear and developmentally appropriate rules for behavior; specific rules about sexual behaviors and boundaries; and corresponding motivators and discipline. Enhancement of parenting skills should address identifying and implementing high levels

of supervision and safety planning of the child with PSB particularly when around other children, as well as how to reduce the intensity of supervision over time based on the child's progress. Caregivers should also learn how to appropriately share with their children the caregiver's beliefs and values regarding relationships, sex, and other relevant issues. The treatment provider is purposefully preparing the caregiver to effectively manage their child's behavior, sexual and otherwise, in the short- and long-term (i.e., post-treatment).

Because PSB in children is a behavior problem, caregivers are the primary agent of change for children's behaviors since they have the most contact with the child and are responsible for raising the child.

CONCLUSIONS AND RECOMMENDATIONS

Children with PSB are a reality in communities, and child-serving systems struggle with how to respond effectively to reduce reoccurrence of PSB and promote healing and safety of all children. The struggles faced by child-serving professionals can be attributed to lack of accurate knowledge, training, and resources, as well as a lack of clear policies and procedures that inform who is responsible and for what. MDTs and CACs are ideally suited to provide a comprehensive response to cases of children with PSB given their missions, structures, collaborative nature, accreditation standards (if applicable), and collective access to resources.

Through the development and implementation of a written investigative protocol specific to children with PSB, MDTs and CACs will have the capacity to more readily engage in best practices when these cases are referred. Interagency agreements and memorandums of understanding signed by leadership of MDT member agencies serve to strengthen the delivery of best practices through collaboration, establishing clear roles and responsibilities, and the integration of those systems involved with cases. Developing these documents and protocols will make clear what is needed to support MDT and CAC members to engage in best practices. For example, requiring training on child sexual development and problematic sexual behaviors, safety planning, understanding effective family engagement, assessment, and treatment, will inform the response by each system involved.

MDTs and CACs would benefit from having access to a mental health provider who can serve as a consultant for the team. This provider should have training on and experience working with children with PSB, their child victims, and their families. This consultant could be available to teams as needed and would provide support and guidance when the team receives a referral of a child with PSB. Having a subject matter expert would elevate the decision-making process for the MDT and CAC when determining next steps.

Family engagement in the MDT process and treatment services is essential. MDT members and CAC staff should use people-first language, specifically "children with problematic sexual behavior" rather than "perpetrator" or "sex offender." Forms, report templates, and data systems should use parallel language. Those with direct contact with the family should convey to the family (and anyone else involved) the seriousness of the child's behavior while simultaneously giving accurate messages of hope for the child with PSB and their family.

Assessment and treatment are critical components of a comprehensive, integrated response by MDTs and CACs. A clinical assessment of a child with PSB should inform individualized treatment recommendations, which should include the participation of caregivers. Research clearly indicates that the vast majority of children with PSB will not have a reoccurrence of PSB when they receive treatment that actively involves their caregivers.

The field of multidisciplinary response to child abuse and the NCA Standards are continuing to evolve to meet the needs of all children, including those with PSB, and their caregivers. Additional research studies regarding effective treatment options for PSB are needed to make quality training and treatment more widely available. Creative solutions are needed, such as further exploration of tele-mental health to deliver treatment, which has been effective in increasing engagement of families in treatment by removing barriers (e.g., transportation, time limitations, access to trained clinicians, and so on).

Having accurate, research-based information regarding the dynamics of children with PSB and clear policies, protocols, and procedures will provide the MDT and CAC with the knowledge they need to effectively respond to and support these children and their families. The CAC/MDT model can be adapted to accommodate cases of children with PSB, while continuing to uphold the tenants of NCA's Standards for Accreditation. By the same token, the MDT approach, even without access to a CAC, can be modified to provide a more child- and family-centered approach to cases involving PSB. As the body of research grows and the NCA standards evolve, updates will be made to this publication in an effort to keep the field apprised of ongoing recommendations.

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RESOURCES

This section contains some of the resources mentioned in this paper in addition to others that may be helpful and are categorized as follows:

Online Resources

PSB Fact Sheets

Virtual Training

CAC-based MDT PSB Programs

MDT PSB Programs in Collaboration with Local CACs

Online Resources

- **California Evidence-Based Clearinghouse for Child Welfare:** <https://www.cebc4cw.org/topic/sexual-behavior-problems-in-children-treatment-of/>
- **National Center on Sexual Behavior of Youth:** www.ncsby.org
- **National Child Traumatic Stress Network:** www.nctsn.org
- **National Children’s Alliance:** <https://learn.nationalchildrensalliance.org/psb>
- **National Institute of Justice—Results in Program Records:** <https://www.crimesolutions.gov/advsearch.aspx>. Enter PSB - CBT in search engine.)
- **Office of Juvenile Justice and Delinquency Prevention Model Programs Guide:** <https://www.ojjdp.gov/MPG/Program>. Enter Children with Problematic Sexual Behavior in search engine.)
- **The University of Oklahoma Health Sciences Center—Problematic Sexual Behavior Cognitive-Behavior Therapy Training and Technical Assistance Program:**
 - Map of Providers—<https://psbcbt.ouhsc.edu/Find-a-Provider/List-of-Providers>
 - Training Resources—<https://psbcbt.ouhsc.edu/PSB-CBT-Training/Resources>

PSB Fact Sheets

From the National Children’s Alliance (NCA)

Effective Treatment for Youth with Problematic Sexual Behaviors

NCA Summary: “New in October 2019, a two-page overview of the best practices and treatment models for youth with problematic sexual behaviors. While all NCA member CACs will be sent several copies of the fact sheet, CACs and partner organizations may download the document free at any time to print additional copies for distribution.”

Link: https://www.nationalchildrensalliance.org/wp-content/uploads/2019/10/YPSB-Effective-Treatment-Fact-Sheet-2019_web.pdf

Where We Begin: CACs and Youth with Problematic Sexual Behaviors

NCA Summary: “This fact sheet is intended for CAC leaders and staff, with guidance on building the response to problematic sexual behaviors, the key role CACs play in addressing this issue, and building community support for the CAC response.”

Link: <https://www.nationalchildrensalliance.org/wp-content/uploads/2018/03/2017-PSB-Fact-Sheet-CACs-2.pdf>

What Can We Do: Understanding Children and Youth with Problematic Sexual Behaviors

NCA Summary: “This fact sheet is an overview of problematic sexual behaviors in youth and children, and includes basic information on the continuum of childhood sexual behaviors, criteria for problematic sexual behaviors, the role of language and science in informing the response, and next steps for communities. It is appropriate for community partners, multidisciplinary team members, and general education on the issue for CAC staff and community members.”

Link: <https://www.nationalchildrensalliance.org/wp-content/uploads/2018/03/2017-PSB-Fact-Sheet-Overview-3.pdf>

What Happens Now: Facing Sexual Behavior Problems with Your Child

NCA Summary: “This fact sheet is intended for caregivers of children and youth with problematic sexual behaviors, with guidance on the how caregivers can help their children and answers to pressing questions caregivers and family members may have.”

Link: <https://www.nationalchildrensalliance.org/wp-content/uploads/2019/01/2017-PSB-Fact-Sheet-Caregivers-1.pdf>

Youth with Problematic Sexual Behavior: Best Practice Documents Overview

NCA Summary: “NCA has convened expert practitioners in addressing youth and children with problematic sexual behaviors in the CAC setting to develop an overview of sample best practice documents.”

Link: https://4a3c9045adefb4cfdebb-852d241ed1c54e70582a59534f297e9f.ssl.cf2.rackcdn.com/ncalliance_6945832601107746aa7ba5b513eb006c.pdf

From the National Child Traumatic Stress Network (NCTSN)

Understanding and Coping with Sexual Behavior Problems in Children: Information for Parents and Children

Created in partnership with National Center for Sexual Behavior of Youth and available in English and Spanish

NCTSN Summary: “Provides parents and caregivers with information about coping with sexual behavior problems. This fact sheet, a part of Caring for Kids: What Parents Need to Know About Sexual Abuse, describes childhood sexual behaviors, causes of sexual behavior problems, what to do if your child has sexual behavior problems, treatment options, and how to keep children safe from sexual behavior problems. Published in 2009.”

Link: <http://www.ncsby.org/sites/default/files/resources/Understanding%20and%20Coping%20with%20SBP%20in%20Children%20--%20NCTSN%20NCSBY.pdf>

General Information PSB-SBT-S: Problematic Sexual Behavior- Cognitive-Behavioral Therapy for School-Age Children

NCTSN Summary: PSB-CBT-S is a family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of problematic sexual behavior. This program involves the family or other support systems in the child’s treatment and requires weekly caregiver attendance and active participation, monitoring and supporting the child’s application of skills between sessions, and ongoing assessment of child progress in treatment. Targeted Populations: 7-12; both males and females; for children with problematic sexual behavior may or may not have a history of trauma.

Link: https://www.nctsn.org/sites/default/files/interventions/psbcbt_fact_sheet.pdf

Culture-Specific Information PSB-CBT-S: Problematic Sexual Behavioral Therapy for School Age Children

Summary: This informational document provides tips for cultural considerations in the following areas: engagement; language issues; symptom expression; assessment; cultural adaptations; and intervention delivery method/transportation & outreach; and training issues.

Link: https://www.nctsn.org/sites/default/files/interventions/psbcbt_culture_specific_fact_sheet.pdf

Sexual Development and Behavior in Children: Information for Parents and Caregivers

Summary: Provides parents and caregivers information on sexual development and behavior in children. This fact sheet, a part of the Caring for Kids: What Parents Need to Know About Sexual Abuse series, helps parents know what typical sexual development looks like in children, respond to sexual behaviors, educate children about sexual issues, and know what to teach children based on developmental age.

Link: <https://www.nctsn.org/resources/sexual-development-and-behavior-children-information-parents-and-caregivers>

Virtual Training

From the National Children's Alliance

Youth with Problematic Behaviors Training: This four-part series, two-hour course provides an overview of youth with problematic sexual behaviors, discusses the CAC coordinated response, presents the characteristics of evidence-based mental health treatment for problematic sexual behaviors, and provides guidance on engaging community stakeholders. It aims to dispel myths and misconceptions about youth with problematic sexual behaviors and help child-serving professionals understand that they can and should serve this population.

<https://learn.nationalchildrensalliance.org/products/youth-with-problematic-sexual-behaviors>

Ask the Experts: Youth with Problematic Sexual Behavior: This webinar was recording in February 2017 and was hosted by experts on addressing problematic sexual behaviors in youth and children.

<https://vimeo.com/208384181>

From the National Child Traumatic Stress Network

Improving Implementation: Evidence-Based Treatments and Practices

<https://learn.nctsn.org/course/index.php?categoryid=72>

Toolkit Curriculum for Learning Collaborative Facilitators

<https://www.nctsn.org/resources/toolkit-curriculum-learning-collaborative-facilitators>

Child Advocacy Center Directors' Guide to Quality Mental Health Care

<https://www.nctsn.org/resources/child-advocacy-center-cac-directors-guide-quality-mental-healthcare>

CAC-based MDT PSB Programs

The following organizations are available for consultation:

Dakota's Children's Advocacy Center

1303 East Central Ave, Bismarck ND 58501

PSB-CBT Program

Serves children ages 7–13

Contact: Paula Condol, Executive Director

pcondol@dakotacac.org

<https://www.dakotacac.org/services/psb/>

Dee Norton Child Advocacy Center

677 Long Point Road, Mt. Pleasant, SC 29464

PSB-CBT Program

Serves school-age children and adolescents

Contact: PSB Program Coordinator or PSB Sub-Specialty Leader

843-723-3600

NCAC (National Children's Advocacy Center)

210 Pratt Ave NE, Huntsville, AL 35801

PSB-CBT Program

Serves children ages 7–12

Contact: Erica Hochberger, LICSW, Intervention and Clinical Supervisor

ehochberger@nationalcac.org

MDT PSB Programs in Collaboration with Local CACs

The following organizations are available for consultation:

MOCSA (Metropolitan Organization to Counter Sexual Assault)

3100 Broadway Blvd. Suite 400, Kansas City, MO 64111-2591

YPSB Program

Serves children ages 7-12

Contact: Virginia Sweetser, Therapist & Counseling Coordinator – YPSB

vsweetser@mocsa.org

Youth Outreach Services Chicago

6417 W. Irving Park Rd., Chicago, IL 60634

Youth Outreach Services Programming for Youth with Problematic Sexual Behaviors

Serves children ages 10–17.5 and adolescents age 13–19

Contact: Peggy Moulton, PSB-CBT Program Manager, margaretm@yos.org

Contact: Margaret Hensley, Program Manager, margareth@yos.org