Youth with Problem Sexual Behaviors in the Child Welfare System: Best practices to support investigation, safety planning and treatment

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CHILDREN'S ADVOCACY
CENTERS of Michigan
A Network of Hope.

Objectives of presentation:

- Participants will learn about current research related to children and adolescents that demonstrate problem sexual behaviors.
- A trauma-informed MDT approach will be reviewed related to the investigation of and safety planning for this population.
- Important elements of assessment (areas to consider) and treatment for this population will be reviewed.
- Case examples will be discussed and resources will be shared.

Children with Problematic Sexual Behavior: Recommendations for the MDT and CAC Response (2020)[1]

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."

Definitions

Defining the sexual behaviors exhibited by children and young people is challenging and a number of definitions exist in the literature.[2]

[2]Malvaso, C., Proeve, M., Delfabbro, P., & Cale, J. (2020). Characteristics of children with problem sexual behaviour and adolescent perpetrators of sexual abuse: A systematic review. *The Journal of Sexual Aggression*, *26*(1), 36-61.

Things to Consider

- General sexual behavior problems vs. interpersonal sexual behaviors
- Problem sexual behaviors vs. sexually abusive behaviors
- Developmental appropriateness- children vs. adolescents
- Who is reporting the behavior? Child vs. parent vs. teacher

Definitions

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).

[1]Children with Problematic Sexual Behavior: Recommendations for the MDT and CAC Response (2020)

Consistent with Healthy Sexual Behaviors (Kellogg, 2010; Silovsky& Bonner, 2004)

- Is exploratory and mostly spontaneous;
- Occurs intermittently and by mutual agreement/assent;
- Occurs with children of similar age, size, or development level;
- Occurs with children who know each other;
- Is not associated with high levels of fear, anger, or anxiety;
- Compliance is more of an internal process
- Decreases when told by caregivers/authority to stop; and/or
- Can be controlled by increased supervision.

Signs of possible PSB (Silovsky& Bonner, 2004)

- Focus on sexuality to a greater extent that other aspects of their environment, more sexual knowledge than similar-aged children.
- Compulsive interest in sexual or sexually related activities, sexual behaviors are more important than being with friends, going to school, and other developmentally appropriate activities
- Child engages in sexual behaviors with those who are much older or younger.
- Child exhibits confusion or distorted ideas about the rights of others in regard to sexual behaviors.
- Child tries to manipulate children or adults in touching their genitals or causes harm to their own genitals

"Survey on Youth with Problematic Sexual Behaviors," conducted by the National Children's Alliance (NCA),

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. [1]

[1]Children with Problematic Sexual Behavior: Recommendations for the MDT and CAC Response (2020)

Myths

#1-The majority of children and adolescents with PSBs have been sexually abused

Myths

#2- Children with problematic sexual behaviors are a high risk to other children in the community

Myths

#3- Youth with problematic sexual behaviors have high recidivism rates

Myths

#4- Assessment and treatment protocols for youth with PSBs should mirror adult sex offender programs

Takeaways from the literature

Taken from: Children with Sexual Behavior Problems: Clinical Characteristics and Relationship to Child Maltreatment (2017)

- Studies by Bonner et al. (1999) and Silovsky and Niec (2002) found that the minority of children with ISBP had a sexual abuse history, suggesting the presence of other causal mechanisms.
- Friedrich et al. (2003) found that sexual abuse history was not the primary factor in the display of ISBP, but rather a model that included other child behavioral problems, parental physical coercion/abuse of the child, and family modeling of sexuality was most predictive.

Takeaways from the literature

Taken from: Impact of early intervention for youth with problematic sexual behaviors and their caregivers (2019)

- More than one-third of sexual offenses against children are committed by other youth in the United States (US; Finkelhor, Ormrod, & Chaffin, 2009; Puzzanchera, Smith, & Kang, 2017) and in the United Kingdom (UK; Hackett, 2014).
- Youth with illegal sexual behavior are surprisingly young. In the US, children under 12 were 23% of arrests of juveniles for rape or sexual assault with an object of victims under 12 in 2016 (Puzzanchera et al., 2017)
- Approximately one quarter of the child victims are related to the youth with illegal sexual behavior (siblings, cousins), and few victims are strangers (Finkelhor et al., 2009; Taylor, 2003).

Takeaways from the literature

Taken from: Impact of early intervention for youth with problematic sexual behaviors and their caregivers (2019)

- As a group, youth with PSB are of much lower risk and have greater responsivity to intervention than policies and common practices would suggest (Chaffin, 2008). Notably, a recent meta-analysis found recent rates of recidivism are improved over earlier recidivism rates, as studies from the 2000s indicate sexual offense recidivism rates of around 2.75%, which was 73% lower than found in studies from 1980–1995 (Caldwell, 2016).
- A meta-analysis found that treatment components that involve direct work with caregivers to address managing child behavior, sex education, abuse prevention, and sexual behavior rules were related to reductions in PSB in children 12 years and younger (St. Amand et al., 2008).

Allen, B. (2016). Children with Sexual Behavior Problems: Clinical Characteristics and Relationship to Child Maltreatment. *Child Psychiatry and Human Development, 48*(2), 189-199.

- Experience of sexual abuse does not appear related to interpersonal forms of PSB (IPSB), only general PSB.
- Physical abuse was the only form of maltreatment significantly related to ISBP. This finding coincides with Friedrich et al.'s [22] finding that modeling of coercive behavior is a primary etiological factor in the development of ISBP. Physical abuse by its very nature necessitates a form of power assertive intrusion on the physical space of another that may or may not be present with other forms of maltreatment (at least as it is perceived by the child). This modeling of the coercive violation of the personal space of others may be a key etiological factor in the development of ISBP.

MDT Education

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

(Review of November 2020 Paper)

Excellent Resources as the end!!!

Challenges for MDT (Geoff Sidoli, 2021)

Legal

- Is sexualized behavior developmentally normative?
- Do the sexualized behaviors meet elements of a crime?
- Do the behaviors cause harm, discomfort, or without consent/assent?
- Based on jurisdiction and statutes

Clinical needs

- Specialized assessment treatment for PSB and/or
- Specialized assessment and treatment for trauma

Safety Planning Considerations

1. Close supervision is important when the child is with other children.

2. The child with problematic sexual behaviors should not sleep in the same bed with other children.

3. Communicate clear rules and expectations about privacy and appropriate sexual behavior to all your family members.

4. Have privacy rules in place.

https://ncsby.org/content/safety-planning#sexualrules

Safety Planning Considerations

5. Personal self-care should occur in private.

6. An adult should remain in charge of all the children.

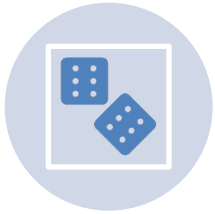
7. Children need to be protected from sexually explicit media.

8. Parents and other adults should demonstrate modesty in the child's presence.

https://ncsby.org/content/safety-planning#sexualrules

Some questions to ask

What is the goal of the safety plan?



What behaviors do we want to increase? Decrease?

Who will be involved?

Who will be responsible/facilitate the plan?

How do the elements of the plan reflect best practice?

How often will the safety plan be reviewed?

Sample Safety Plans

- NCSBY Family Safety Plan
- Best Practices Documents Overview

Case Presentation

- 10-year-old identified as male. Adopted. Presented at CAC following interview – Older peer grooming behaviors
- Concern about possible masturbation in the presence of younger sister
- Secondary issue that parents requested therapy for- excessive masturbation
- Trauma History-neglect, significant exposure to pornography
- Treatment focus- anxiety, unhealthy calming behavior in response to stress
- Parental support and education- “reframing”

Psychosexual Assessment vs. Clinical Assessment

What is needed for this population?

Clinical Assessment Considerations (Geoff Sidoli, 2021) Common Acceptable Terms

- Harmful sexual behavior
- Sexually reactive
- Abuse reactive
- Sexually intrusive behavior
- Sexually aggressive
- Sexual acting out
- Sexually abusive behavior
- "interpersonal" (behaviors that involve other children) or "non-interpersonal" (behaviors that are entirely self-focused)
- Sexual behavior problems/Problematic sexual behaviors

Clinical Assessment Considerations (Geoff Sidoli, 2021)
Challenges for MDT

- PSB is nonrelational (one child)
  - Is the behavior normative?
  - Is it a legal issue?
    - Child pornography
    - Paraphilias (public masturbation, bestiality)

- PSB is relational (multiple children)
  - Is the behavior normative?
  - Is it a legal issue?
    - Involves coercion, force, manipulation, pressure
    - Causes harm, anxiety, discomfort, adverse response

Clinical Assessment Considerations (Geoff Sidoli, 2021)
What is a PSB?

- Determining where sexual behavior falls:
  - continuum of normative (biologically, socially, culturally)
  - concerning (to adults and/or children)
  - problematic (adverse consequences) in infrequency, duration, emotional responses, and ages/abilities of the children.
- Evaluate each case on the developmental issues within the context of their life experiences
- There is more agreement on what behaviors are abusive than on what behaviors are developmentally expected, particularly in older children. Data on normative behaviors is old (2010).

Questions to ask related to trauma (Allen 2018)

1. Did the PSB begin before or after the identified traumatic event(s), or was it exacerbated by the trauma?

2. What specific types of PSB are present?

3. How frequently does the identified PSB occur, and what is the caregivers' response?

Clinical Assessment Considerations (Geoff Sidoli, 2021)

How do we differentiate the potential good from the potential bad?

- Pornography
- Masturbation
- Sexual thoughts/fantasy
- Hands off sexual acts (peeping, exhibitionism, etc.)
- Language
- Gestures
- Hands on sexual acts

Clinical Assessment Considerations (Geoff Sidoli, 2021)

Risks to Consider

- Victimization/Abuse/Neglect/Trauma
- Nonsexual re-offense/offense
- Mental Illness
- Self-harm/Suicide
- Placement Stability
- School Failure
- Substance Abuse
- Familial Discord

Clinical Assessment Considerations (Geoff Sidoli, 2021)

- Family dynamics/ history/makeup/relationships
- Resiliency/protective factors
- Mental and organic disorders/Psychopathology
- School/academic issues
- Drug/alcohol use
- Social, family, environment issues
- Cultural, spiritual, socio-economic
- Developmental history (biological, psychological, moral)
- **Trauma history**
- Self-perception/image
- Sexual history, interests, and knowledge
- Denial/deception
- Violence and/or coercion
- Medical concerns*

Assessment Tools- What can/should we measure?

- General Screening-
  - BASC-3
  - CBCL
- Trauma Screening
  - UCLA PTSD
  - CPSS-5 CATS
  - TSCC
- Substance Use
  - SA Screening tools
- Racial Trauma https://www.mentalhealthdisparities.org/trauma-research.php

Assessment Tools- What can/should we measure?

- Screening Tools List
- The Child Sexual Behavior Inventory-III Sample report
- Parenting Stress Index PSI Short Form 4

PSB Treatment Training Options

Advanced TFBCT for PSB – 1.5 Day training
PSB-CBT- Learning Collaborative
PCIT for PSB
MST PSB
Penn State Program, Brian Allen: Provider info

How do we determine which option(s) to pursue?

Advanced TFCBT for PSB

Virtual and live trainings available

Easily added to TFCBT protocol

Training Link

PSB-CBT- Learning Collaborative

- Positive research outcomes
- Extensive training and support
- Training overview

PCIT for PSB

Adaptation of already existing protocol

Training overview

MST for PSB

Adaptation of well-established EBT

Overview

Penn State Program, Brian Allen

Currently in clinical trials

Training avialable

Provider info

Brian Allen, Lucy Berliner, Chad E. Shenk, Brianna Bendixsen, Anne Zellhoefer, Cassie R. Dickmann, Bethany Arnold & Michelle J. Chen (2018) **Development and Pilot Testing of a Phase-Based Treatment for Preteen Children with Problematic Sexual Behavior**, Evidence-Based Practice in Child and Adolescent Mental Health, 3:4, 274-285, DOI: 10.1080/23794925.2018.1515580

Protocol Development

1. The protocol must be based on the current empirical evidence related to the treatment of PSB and child behavioral concerns in general.

2. The protocol must be appropriate for use with trauma-exposed children as well as those children without known trauma exposure.

3. In recognition that PSB often presents with a host of other concerns, the protocol must sufficiently address the PSB while remaining flexible enough that it can supplement evidence-based treatments for other emotional and/or behavioral problems.

Development and Pilot Testing of a Phase-Based Treatment for Preteen Children with Problematic Sexual Behavior

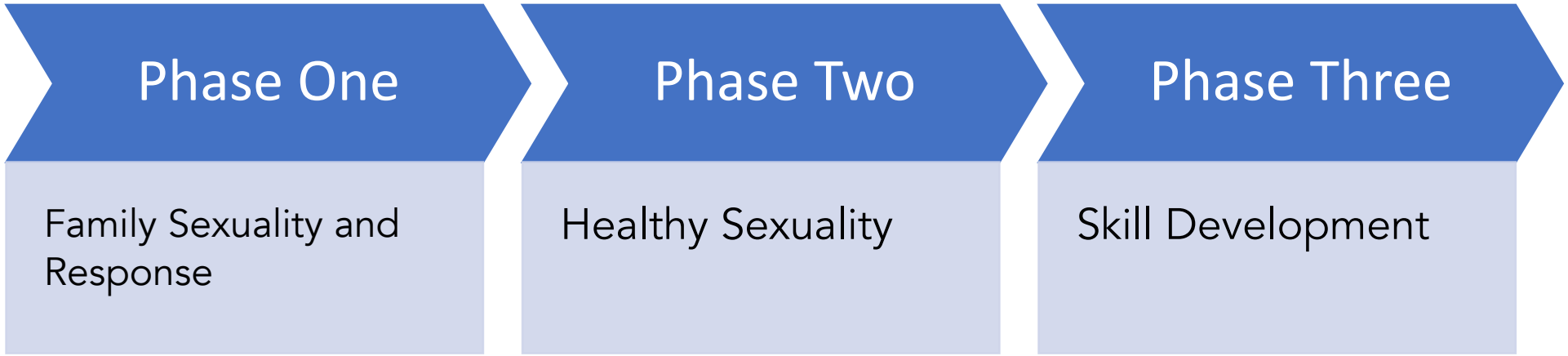
Protocol Development

4. The protocol must allow for assessment-driven tailoring of treatment. This guideline was informed by recognition that both the phenomenology and etiology of PSB are quite diverse and reflect a belief that the treatment must be responsive to the identified strengths and needs of a given child and family.

5. The protocol must capitalize on the existing skill set of practicing clinicians and coincide with the practicalities of community-based practice. This last guideline was identified to maintain a focus on feasibility, dissemination, and implementation of the protocol.

Development and Pilot Testing of a Phase-Based Treatment for Preteen Children with Problematic Sexual Behavior

Treatment Phases



Assessment Protocol: Child Sexual Behavior Inventory, Family Sexuality Index, Safety Checklist, Strengths and Difficulties Questionnaire, TSC-YC

Clinical and Family Support

National Center on the Sexual Behavior of Youth :ncsby

Intervention Resource

What are the essential pieces of family and caregiver education?

Case Presentation

- 12-year-old, identified as male. Sexual intercourse and touching with 10-year-old niece. His niece was interviewed and referred for services and he was interviewed and referred for services. – Logistical issues
- Adopted at 5 years. Two years of foster care after removal from bio parents. Significant physical, sexual abuse, and neglect. Abuse was normalized. Anxiety-based focus for treatment. Significant preoccupation/rumination with sexual abuse. (Brain drawing intervention/monitoring) Medication referral
- Family involvement and impact on functioning and relationships-mother provided childcare for niece, holidays
- Victim family involvement/response
- Family Session with victim's parents
- Romantic relationship development