

TRAUMA-INFORMED MENTAL HEALTH SERVICES FOR CACS IN NC



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Children and Family Services



AGENDA

- Referral and Assessments
- Resources re: trauma, EBTs, and providers
- Overview of TF-CBT
- Overview of PSB-CBT
- Other assessments and treatments



REFER ALL CHILDREN WHO RECEIVE CAC SERVICES (FORENSIC INTERVIEW AND/OR CME)

- Typically need to be at least 3 years-old
- Benefits:
 - 1) Overall mental health checkup– we assess for both child/family strengths and potential mental health issues
 - 2) To provide education, normalize, and provide hope (e.g., normal reactions to abnormal events)
 - 3) To praise resilience/support

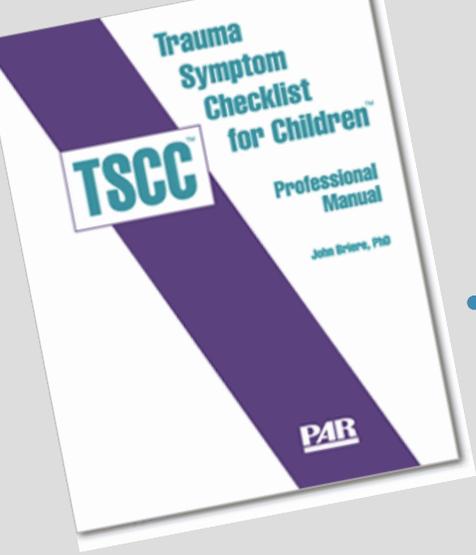


- If indicated, to refer to needed MH services
 - TF-CBT (our primary model for treating trauma symptoms in children and adolescents)
 - Other trauma-informed EBT (EMDR, SPARCS, PCIT)
 - Other treatments (CBT, parenting)

WHEN REFERRING FOR A MH ASSESSMENT

- Findings from CMEs and other evaluations are extremely valuable
- Language referring for a MH assessment is most helpful when concerns and symptoms are clearly described.
- Referring for a specific treatment prior to the mental health assessment can be problematic. [WHY?](#)
- Best to refer for a trauma-informed mental health assessment to determine if an EBT is warranted.





ASSESSMENT PROCESS

- **Comprehensive Clinical Assessment (CCA)**
 - Initial thorough evaluation of child's mental health symptoms, strengths, family system, functioning across all areas; determine recommendation for Level of Care
- **Standardized Assessment Measures**
 - E.g., UCLA PTSD Reaction Index- trauma exposure and symptoms
 - Revised Children's Anxiety and Depression Scale
 - Parent functioning screeners- Patient Health Questionnaire-9; General Anxiety Disorder-7
 - Family Strengths, Supports, and Stress
 - Children's Sexual Behavior Inventory
- **Feedback of results and recommendations to child and family**
 - If treatment recommended, what type, and developing treatment plan

POTENTIAL TREATMENTS

Trainings
offered by
NC CTP

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Problematic Sexual Behavior Cognitive Behavioral Therapy (PSB-CBT)
- Parent-Child Interaction Therapy (PCIT)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Child-Parent Psychotherapy (CPP)

- Eye Movement Desensitization and Reprocessing Therapy (EMDR)
- Other supports (e.g., Resource Parenting Curriculum)



WHAT HAPPENS NOW

Facing Sexual Behavior Problems With Your Child

Discovering that your child has a problematic sexual behavior can be overwhelming. It can bring about a flood of emotions, from anger to sadness, denial, shame and guilt. Having the right help and support is vital to helping your child and assisting you in gaining a sense of hope for the future. You are not alone. Help is available.

RESOURCES

BOOKMARK
THIS

- <https://www.ncchildtreatmentprogram.org/program-roster/>
 - Find a trained provider
- <https://www.cebc4cw.org/>
 - EBT scientific and welfare relevance
- <https://www.nctsn.org/>

The Latest

[Talking to Children about War](#)
[Trauma-Informed Guiding Principles for Working with Transition Age Youth: Provider Fact Sheet](#)
[Talking About Suicide with Friends and Peers](#)
[Psychological First Aid for Displaced Children and Families](#)

Major Events

[COVID-19 Resources](#)
[Tornado Resources](#)
[Military and Veteran Families](#)
[PFA and SPR](#)

Trauma Types

Bullying

Bullying is a deliberate and unsolicited action that occurs with the intent of inflicting social, emotional, physical, and/or psychological harm to someone who often is perceived as being less powerful.

Trauma Treatments

Child and Family Traumatic Stress Intervention

CFTSI is a brief (5-8 session), evidence-based early intervention for children 7 to 18 years old that reduces traumatic stress reactions and the onset of PTSD. CFTSI is implemented within 30-45 days following a traumatic event or the disclosure of physical or sexual abuse.

Trauma-Informed Care

Schools

Children's reactions to trauma can interfere considerably with learning and behavior at school. Schools serve as a critical system of support for children who have experienced trauma.

NCTSN Resources

Rosie Remembers Mommy: Forever in Her Heart Video

Brings to life the story of Rosie, a young girl who is struggling after the death of her mother. This video walks you through Rosie's story and illustrates how a parent can provide solace and support to a child after the death of a loved one.

Resources By Audience



Families and
Caregivers



Child Welfare
Professionals



Justice System
Professionals



School
Personnel



Healthcare
Providers



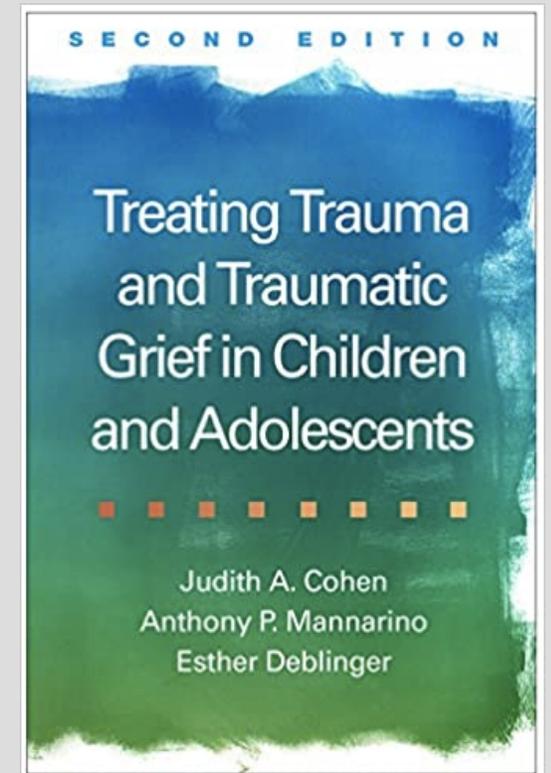
Youth



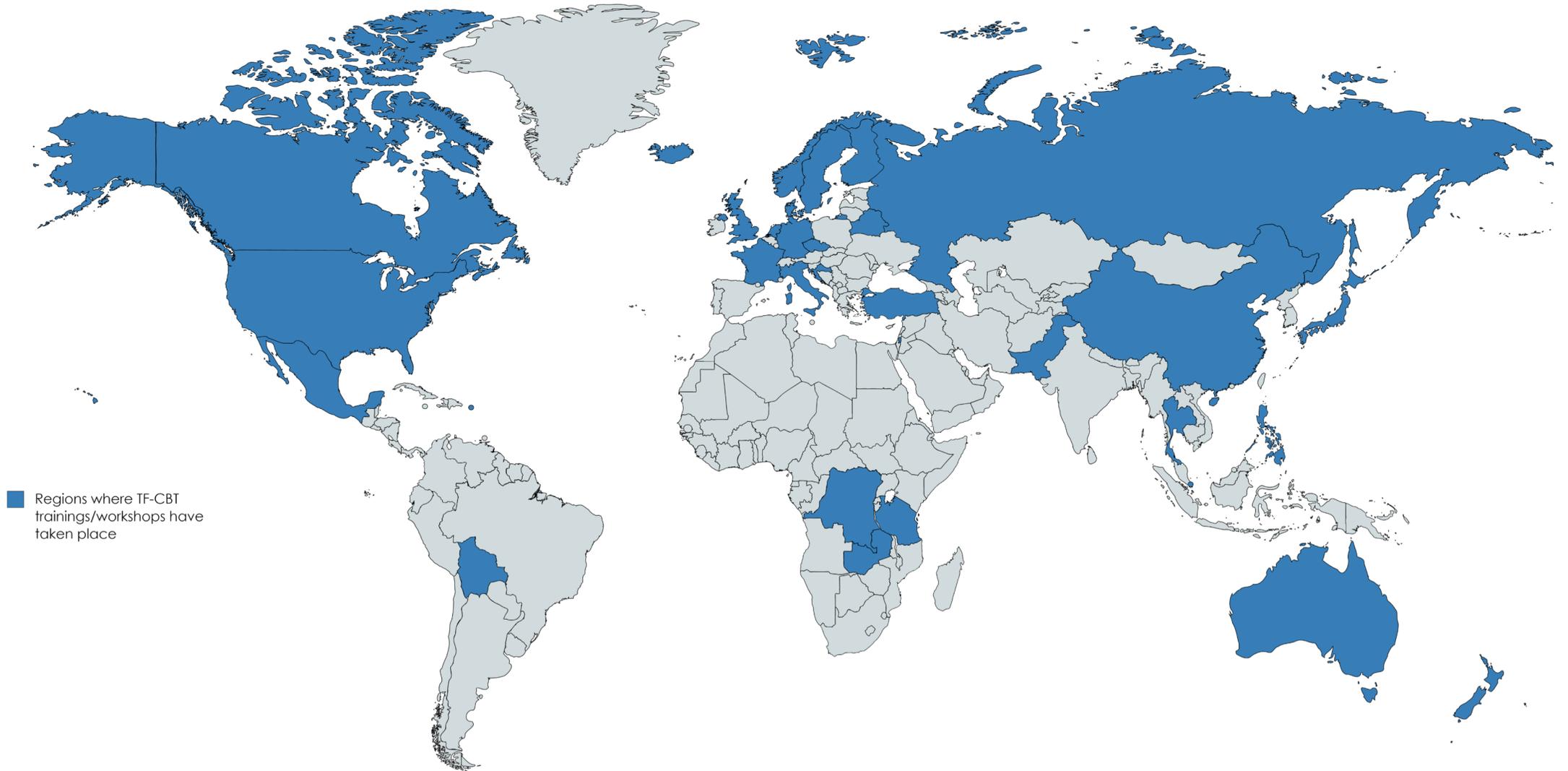
Policy Makers

TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

- **The gold standard in treatment for childhood trauma and traumatic grief**
- California Evidence-Based Clearinghouse for Child Welfare Scientific Rating = 1(well-supported by research evidence); High relevance (<http://www.cebc4cw.org/>)
- 21 RCTs supporting TF-CBT
- Shown to reduce children's traumatic symptoms as well as symptoms of depression and behavioral problems, and to improve parent functioning
 - 80% experience significant improvements in < 16 weeks
- Treatment completed typically in 4-6 months
- Involves child and **supportive caregiver** in developing coping skills and effectively managing trauma and other MH symptoms



As of 2020 TF-CBT has reached these countries/regions



■ Regions where TF-CBT trainings/workshops have taken place

WHEN TF-CBT IS INDICATED



TF-CBT is indicated when

- 3-18 year old experiences trauma resulting in significant behavioral problems, emotional problems, and distress symptoms. This treatment is conducted with the child and nonoffending parent.
- Child not in acute distress/suicidal/actively psychotic

*Not all children who experience trauma need trauma-informed treatment.

*Also used to treat child traumatic grief

WHY IS IT SO IMPORTANT TO INVOLVE CAREGIVERS?

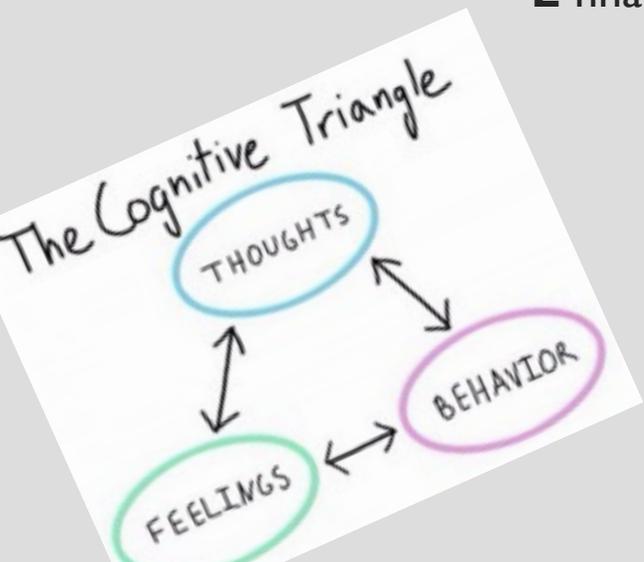
- Research shows that children benefit the most from MH therapy when their caregivers are involved.
 - Parent treatment = decreased behavioral and depressive sx in child
 - Parents' emotional reaction to trauma is one of strongest predictor of treatment outcome (other than treatment type)
 - Parental support significant at 12-month follow-up
- Kids are developing within a family context (not in isolation)



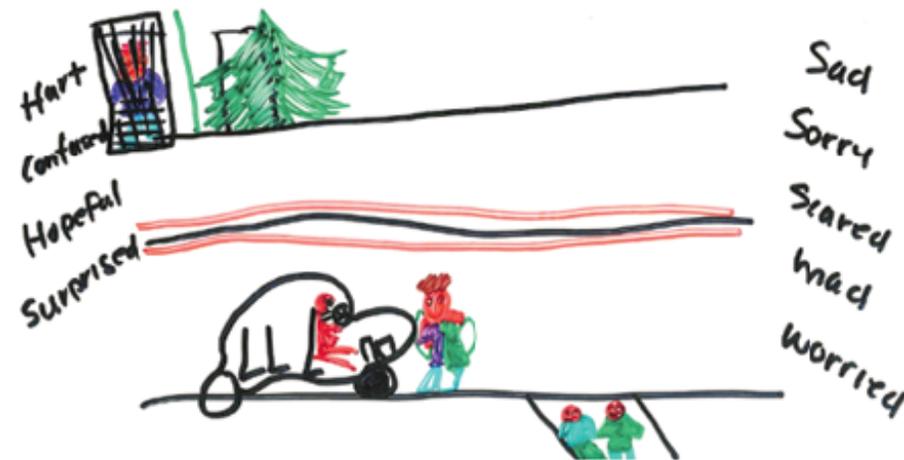
- Typically in therapy up to 1 hour per week with therapist, leaving **HOW MANY** hours of the week *not in therapy*. Practice/skill-building is required at home.
- Caregivers manage behaviors and symptoms and **PRAISE**.
- Therapy is time-limited. Caregivers are the ones carrying on the torch.

PRACTICE TF-CBT

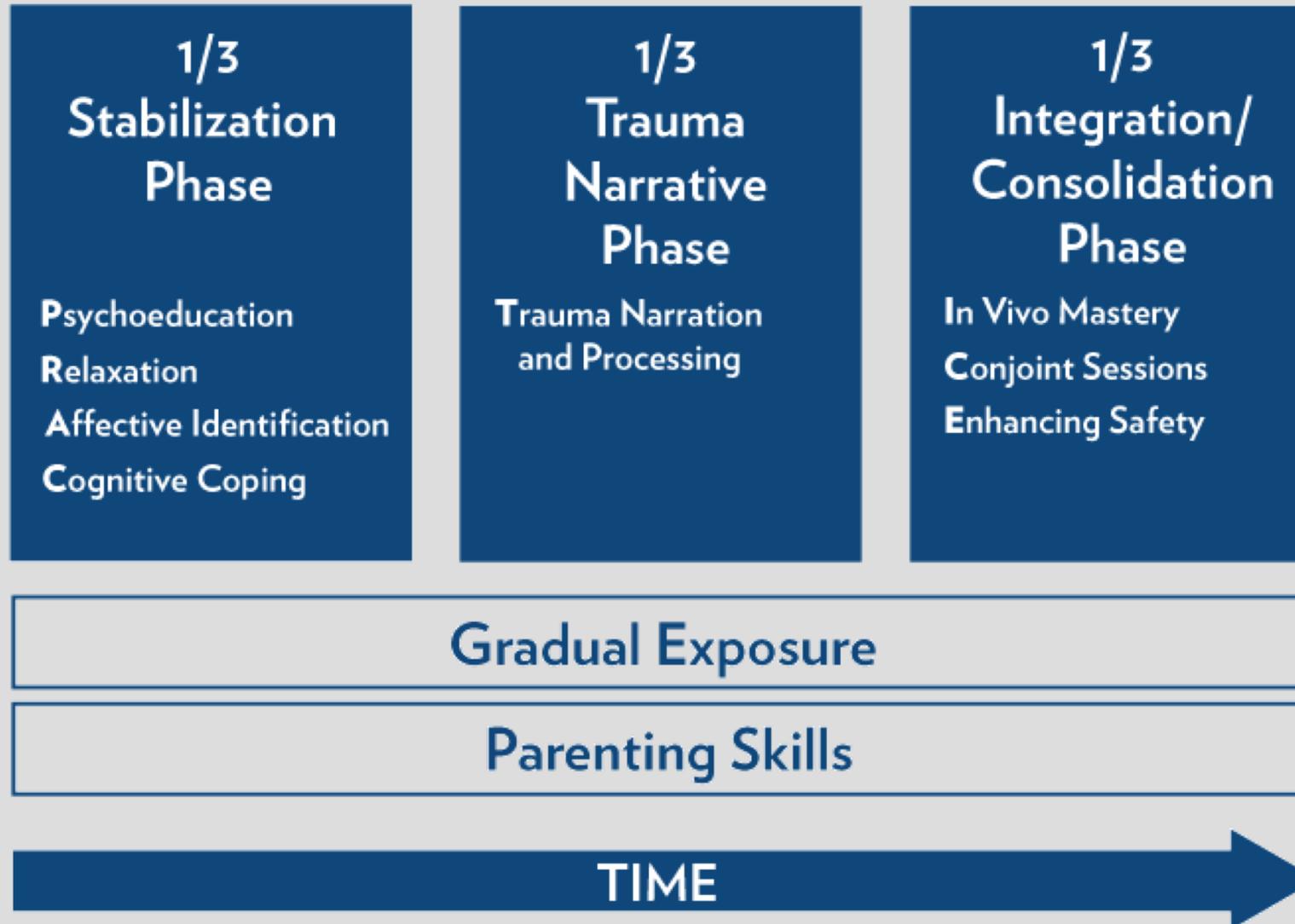
- **P** sychoeducation and Parenting Strategies
- **R** elaxation
- **A** ffective expression and regulation
- **C** ognitive coping/processing
- **T** rauma narrative
- **I** n vivo exposure
- **C** onjoint parent child sessions
- **E** nhancing personal safety and future growth



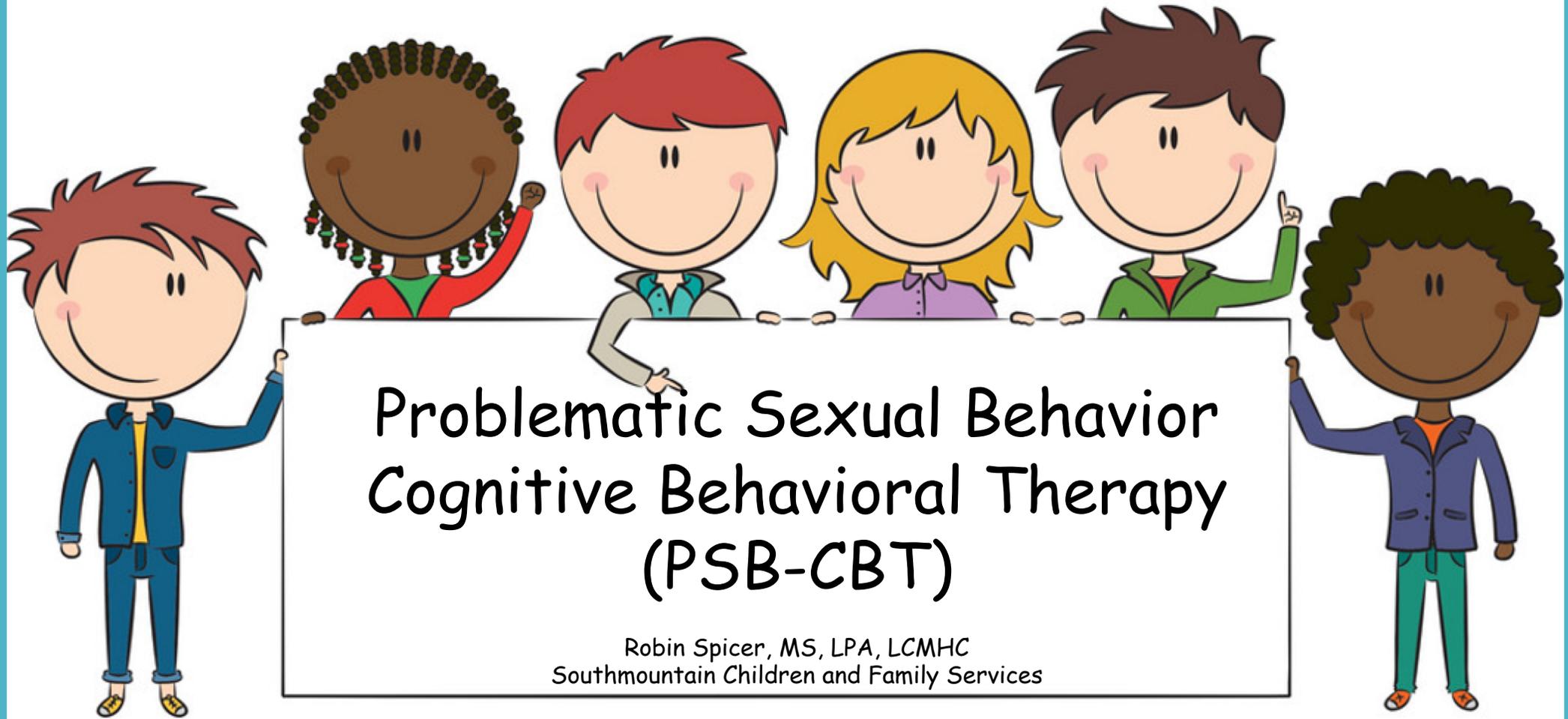
After school we got off the bus and crossed the street to the Robert's house. The Robert kids rode the bus with me and my brother. We talked for about 5 minutes. There was a car coming. It was speeding Tommy didn't see the car. He tried to cross the street. The car hit him. He landed on the street head first.



TF-CBT Pacing



Video if time



Problematic Sexual Behavior Cognitive Behavioral Therapy (PSB-CBT)

Robin Spicer, MS, LPA, LCMHC
Southmountain Children and Family Services

WHAT IS PROBLEMATIC SEXUAL BEHAVIOR IN CHILDREN AND YOUTH?

Children and adolescents may exhibit a **wide range of developmentally-typical** sexual behaviors involving self and others

Becomes problematic when:

Causes harm or potential harm to self or others

Occurs frequently and behaviors are intrusive

Does not respond to caregiver intervention or legal and other consequences

Occurs in response to negative emotional states; anxiety, shame, fear or anger

Occurs between children/youth of vastly different ages or abilities

Aggressive and/or coercive and can elicit fear and anxiety in other children

Interferes with child/youth's social development, school status, placement, etc.



ORIGINS OF PROBLEMATIC SEXUAL BEHAVIOR

Historical assumption – “All children with sexual behavior problems have been abused”

Percentage of sexual abuse history in children with PSB samples (4%-98%)

Sexual abuse maybe more likely in female children with PSB

Problematic sexual behavior usually occurs when the child:

feels anxious or angry and is trying to calm themselves down

is reacting to trauma

is overly curious after being exposed to sexual material

is seeking attention

Problematic sexual behavior may exist along with:

-neglect and/or physical abuse

-exposure to violence

-exposure to sexualized environment or sexually explicit media

-substandard parenting practices



CHARACTERISTICS OF PROBLEMATIC SEXUAL BEHAVIOR

Compared to adult sexual offenders, most children/youth with PSB:

- Have problematic sexual behaviors typically have low impulse control, poor social skills, and poor decision making ability
 - Have fewer victims and behaviors, shorter duration of behavior
 - Engage in fewer behaviors involving penetrative acts
- Have different motivations for their behavior; more experimental or curiosity driven behaviors
 - Less specific, focused sexual behavior
- Less evidence of sexual compulsivity, “cycles,” “grooming” or other features often found in adults
- No evidence that most have a lifelong, incurable sexual disorder or paraphilia

PREVALENCE OF PROBLEMATIC SEXUAL BEHAVIOR

No research or evidence on prevalence and/or incidence

Greater than one-third of sexual offenses against child victims are committed by other youth.

PSB primarily occurs with other children known by the youth, with a quarter of victims being family members.

Few sexual offenses of youth involve strangers.

SUPPORTING EVIDENCE FOR PSB-CBT TREATMENT

The majority of children and youth who participate in PSB-CBT cease to engage in problematic sexual behaviors; the recidivism rate in school age children is 2% at ten-year follow-up (Carpentier, Silovsky, Chaffin, 2006).

Children and youth who participate in PSB-CBT also show significant improvement in non-sexual behavior problems, emotional difficulties, and trauma symptoms (Silovsky, Hunter, Taylor, 2019).

Decrease in parenting stress and increase in parenting skills (Silovsky, Hunter & Taylor, 2019).

Most children and youth benefit from outpatient PSB-CBT, avoiding the cost and disruption associated with out-of-home placement.



PSB-CBT

Originally developed by Barbara Bonner, Eugene Walker (University of Oklahoma Health Sciences Center) and Lucy Berliner (University of Washington)

Revised by Jane Silovsky and the PSB treatment team at OUHSC with goal of halting problematic sexual behaviors, creating/maintaining safety across environments, and improving parenting skills and effective family communication.

Group and Family Treatment Models for children and youth and their caregivers:

**School-age: *ages 7-12*

**Adolescent: *ages 13-18*

Since January 2020, our PSB-CBT School Age Team has assessed 44 children and 25 children have completed treatment with excellent outcomes! Twelve children are currently in treatment; 2 children are scheduled for assessment. Our PSB-CBT-Adolescent Team (currently in training) has assessed 10 youth and are serving 7 youth, with 3 youth scheduled for assessment.



PSB-CBT School-Age Family Model

For children ages 7-12 years

- Cognitive-behavioral and social ecological approach
- 16-18 weekly sessions lasting 60 – 90 minutes
- Requires active involvement of caregivers



Children are referred for behaviors including:

- *Behaviors which cause harm or potential harm to self or others
- *Behaviors occur frequently and are intrusive
- *Behaviors do not respond to caregiver intervention
- *Sexual behaviors considered atypical for the child's age and developmental level

When evidence-based treatments models are followed with fidelity and protective factors are enhanced, PSBs decrease and recidivism rates decline!

PSB-CBT-Adolescent Family Model

For youth ages 13-18 years

- Cognitive-behavioral and social ecological approach
 - Treatment is typically 40-52 weeks
 - Requires active involvement of caregivers
- Most youth can live at home without jeopardizing safety of other youth
- Most youth do not continue to have sexual behavior problems into adulthood

Youth are referred for behaviors including:

- *Initiating PSBs towards children/youth, aggressive and/or coercive and can elicit fear and anxiety in other children/youth
 - *Causes harm or potential harm to self or others
 - *Repeatedly exposing themselves to others
- *Sexual behaviors considered atypical for youth's age and development level

OUR REFERRAL PROTOCOL TO PSB-CBT ASSESSMENT

PSB-CBT Referrals may be facilitated **after** the CAC clinician conducts a CCA utilizing the CSBI (Child Sexual Behavior Inventory) or the YSBPI (Youth Sexual Behavior Problems Inventory.) Then a PSB-CBT Team clinician will conduct the PSB-CBT assessment to ascertain if PSB-CBT specific treatment is the optimal model. The clinician or family advocate will send PSB-CBT School Age Referral (Ages 7-12) to Robin Spicer at rspicer@southmountain.org. The PSB-CBT-Adolescent Referral (Ages 13-18) is sent to Robin Spicer or Brenda Patton at bpatton@southmountain.org.



WORDS FROM NATIONAL CHILDREN ALLIANCE ON PROBLEMATIC SEXUAL BEHAVIOR

“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”.



Click on [National Children's Alliance](https://learn.nationalchildrensalliance.org/psb)

Go to Resources

Addressing Youth with PSBs to view excellent training videos and access multiple resources!



The screenshot shows the NCA Learning Center website. The browser address bar displays <https://learn.nationalchildrensalliance.org/psb>. The main header features the text "Welcome To NCA Learning Center" over a background image of people sitting on a red sofa. Below the header is a sidebar with "LEARNING TOPICS" and a main content area titled "ADDRESSING YOUTH AND CHILDREN WITH PROBLEMATIC SEXUAL BEHAVIORS".

LEARNING TOPICS

- COVID-19 Resources for CACs
- Adding New Users to Engage
- Addressing Youth with Problematic Sexual Behaviors
- Archived Webinars
- CAC-Military Partnerships
- Child Physical Abuse
- Child Victim Web
- Child Sexual Exploitation Resource Toolkit
- Enhance Early Engagement (E3) Training
- Trainings & Events Calendar
- Telehealth Resources

ADDRESSING YOUTH AND CHILDREN WITH PROBLEMATIC SEXUAL BEHAVIORS

Resources For CACs, Partners, And Caregivers

In 20-25% of cases handled by Children's Advocacy Centers (CACs), youth or children under age 18 have acted out against another child.¹ Research also shows that a similar proportion (23.2%) of sexual assaults are committed by juveniles.² 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.

The process of identifying and responding to PSBs among youth and children is often fragmented and inconsistent across the country. CACs are leaders in supporting families impacted by child abuse through coordinated multidisciplinary response and care. This uniquely qualifies CACs to coordinate effective interventions for this population. Below is a set of all-new resources for CACs to educate leaders, staff, partners, and caregivers on this crucial issue and to help improve the CAC response to problematic sexual behaviors.

New Fact Sheet On Effective Treatment

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.

For more information about the information in this fact sheet, go to

- National Center on the Sexual Behavior of Youth (ncsby.org)
- Association for the Treatment of Sexual Abusers (atsa.com)
- OJJDP Crime Solutions (crimesolutions.gov/default.aspx)

Effective Treatment for Youth with Problematic Sexual Behaviors

Best Practices for PSB Treatment for Youth

1. **Identify and Respond to PSBs** - Identify and respond to PSBs as early as possible to prevent further harm and ensure the safety of the youth and others.
2. **Provide Individualized Treatment** - Provide individualized treatment based on the youth's needs and the severity of the PSBs.
3. **Use Evidence-Based Treatment Models** - Use evidence-based treatment models such as the Multisystemic Therapy (MST) and the Functional Family Therapy (FFT).
4. **Monitor and Evaluate Treatment** - Monitor and evaluate the youth's progress and treatment outcomes.
5. **Provide Supportive Services** - Provide supportive services such as counseling, case management, and family support.
6. **Ensure Cultural Competence** - Ensure cultural competence in the treatment and support services.
7. **Provide Trauma-Informed Care** - Provide trauma-informed care that recognizes the impact of trauma on the youth's behavior.
8. **Ensure Safety** - Ensure the safety of the youth and others throughout the treatment process.

Evidence-Based Treatment Models

Multisystemic Therapy (MST) - A comprehensive, evidence-based treatment model for youth with PSBs that addresses the youth's behavior, family, and community.

Functional Family Therapy (FFT) - A brief, evidence-based treatment model for youth with PSBs that focuses on improving family functioning and reducing the youth's PSBs.

Possible Questions to Discuss as a Team

- * What have the caregivers observed the child/youth doing and how often is it occurring?
- * How did the caregiver respond?
- * Did it cause emotional distress or physical injury to the child or other children?
- * Are the PSBs affecting the child/youth's social development or resulting in legal consequences?
- * Was there any force, coercion or intimidation used?
- * Does the child/youth respond to correction, redirection and/or consequences?
- * Is there a significant age/developmental difference between the children/youth?

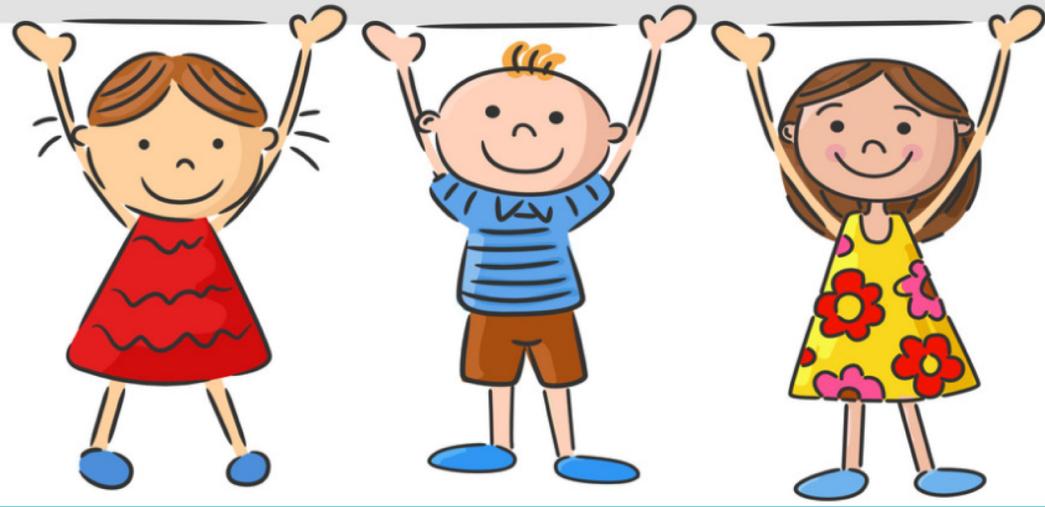


SEXUAL BEHAVIOR RULES FROM PSB-CBT School Age Model

- * It is **NOT OK** to show your private parts to other people.
- * It is **NOT OK** to look at other people's private parts.
- * It is **NOT OK** to touch other people's private parts.
- * It is **OK** to touch your own private parts, as long as you are in private and do not take too much time.
- * It is **NOT OK** to use sexual language.
- * It is **NOT OK** to make other people uncomfortable with your sexual behavior.



There is hope through treatment



OTHER EVALS OF INTEREST

- Custody Evals
- Parenting Capacity Evals
- Child and Family Evaluations
- Developmental and psychological evaluations



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