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

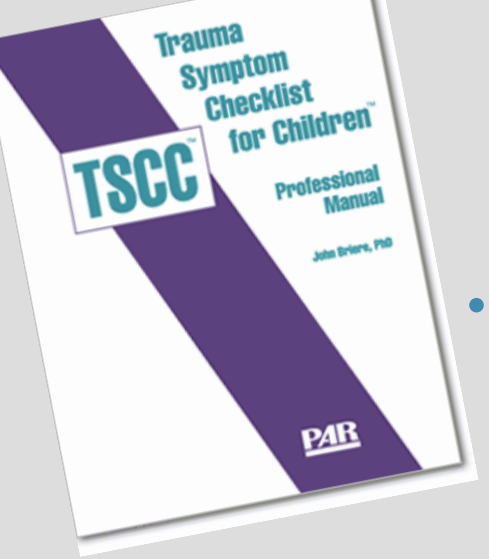
REFER ALL CHILDREN WHO RECEIVE CAC SERVICES (FORENSIC INTERVIEW AND/OR CME)

- 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 a 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 Questionniare-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

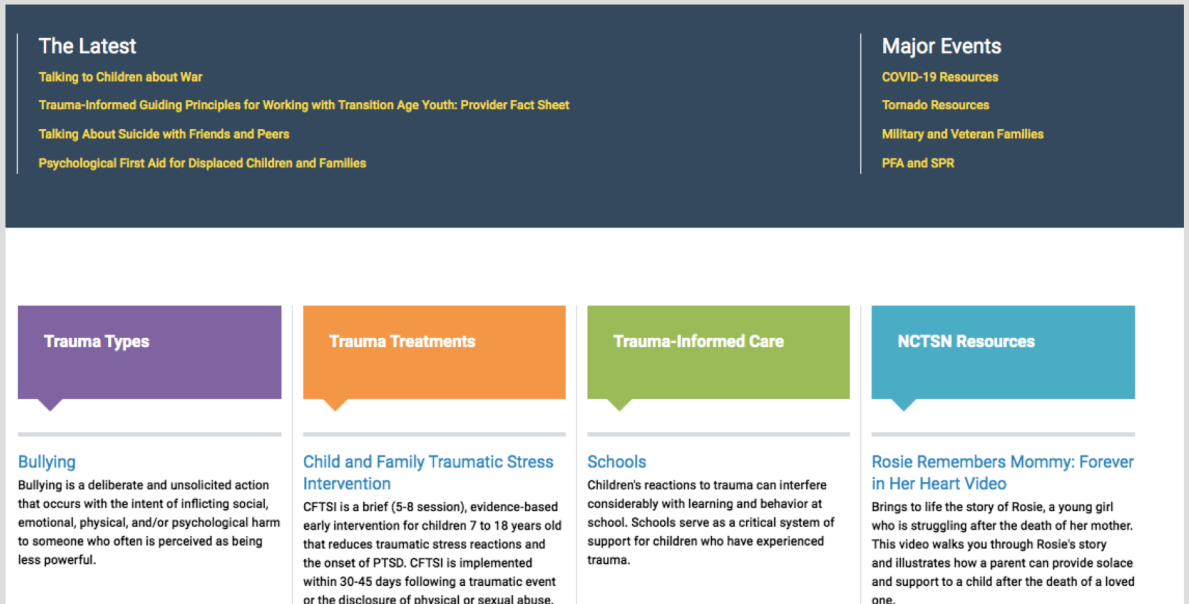
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
- Problematic Sexual Behavior Cognitive Behavioral Therapy (PSB-CBT)
- Parent-Child Interaction Therapy (PCIT)
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
- Child-Parent Psychotherapy (CPP)

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

BOOKMARK THIS

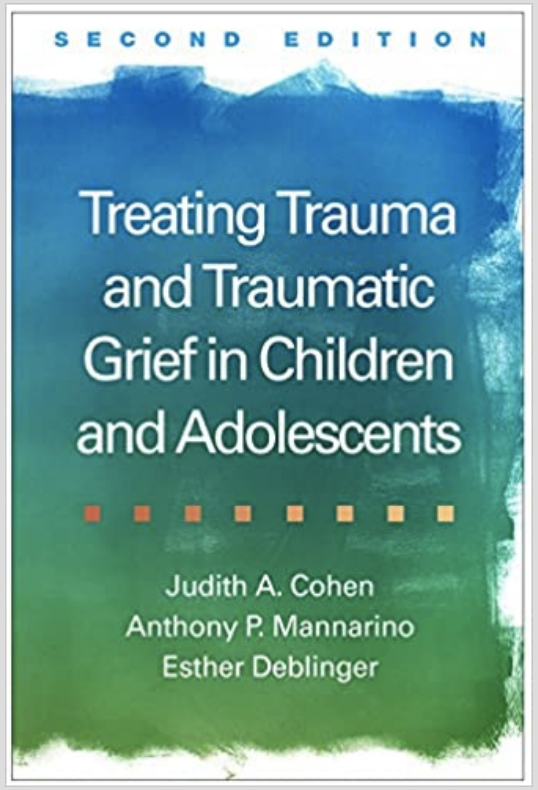
RESOURCES

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

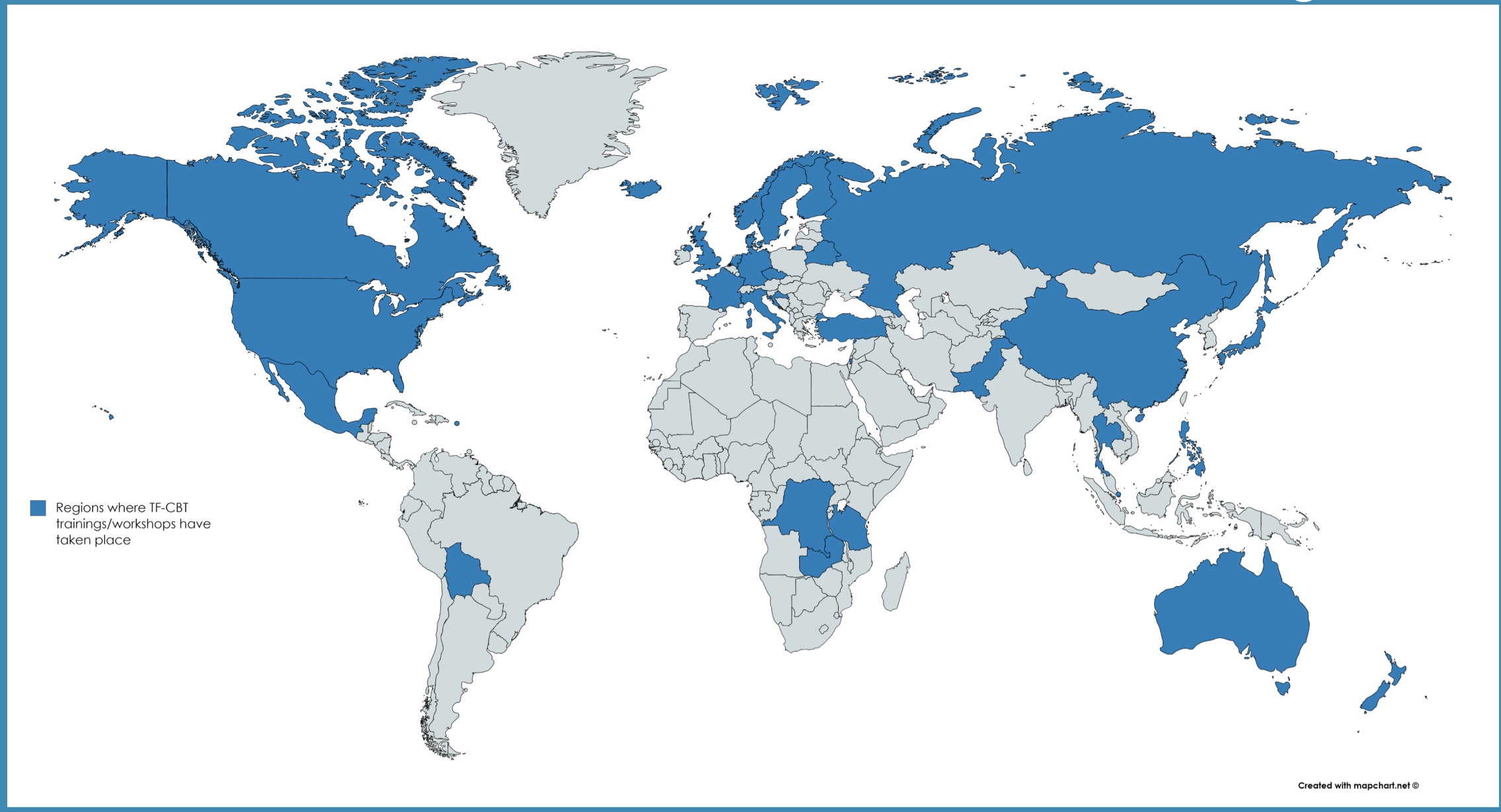


TRAUMA-FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

- **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



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?

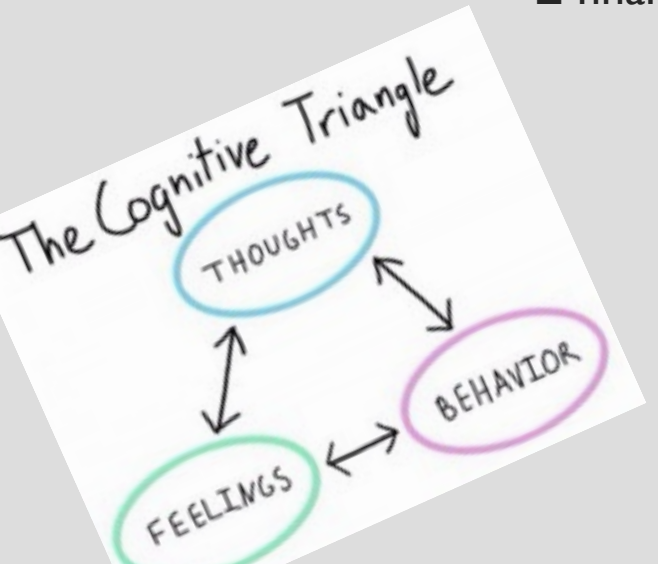
- Research shows that children benefit the most from MH therapy when their caregivers are involved.
  - Parent treatment = decreased behavioral and depressive sx in child
  - Parents' emotional reaction to trauma is one of strongest predictor of treatment outcome (other than treatment type)
  - Parental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

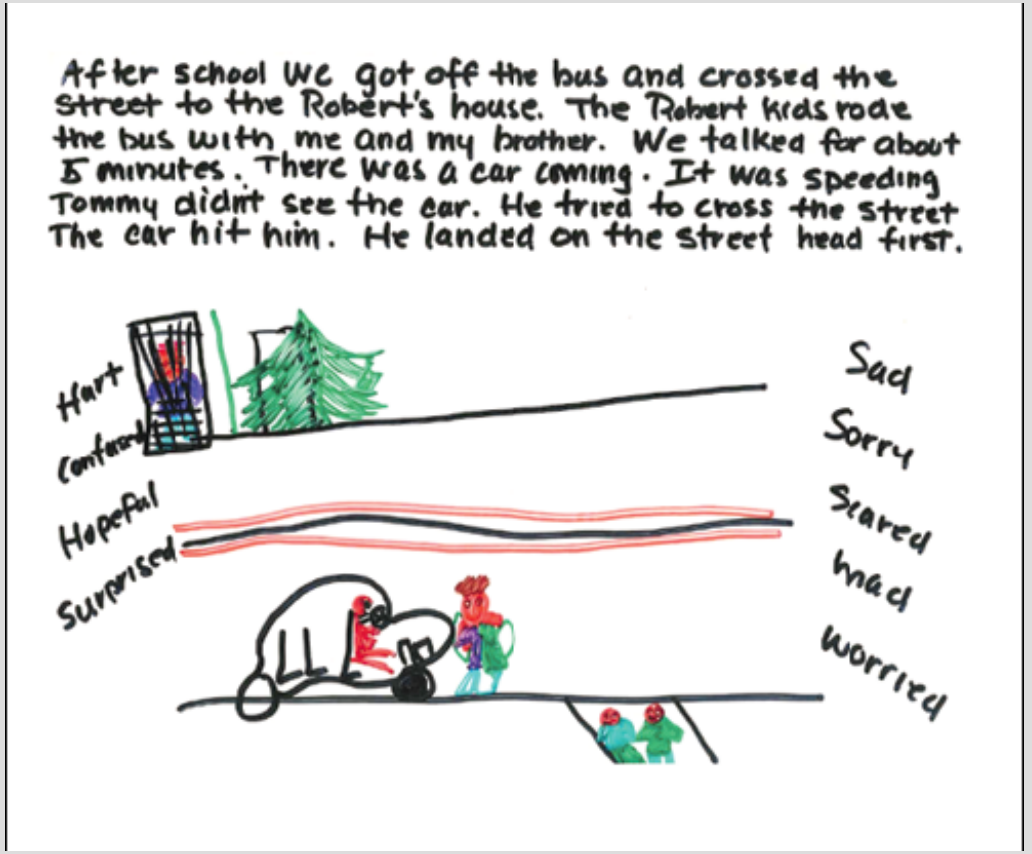
- Typically in therapy up to 1 hour per week with therapist, leaving HOW MANY hours of the week *not in therapy*. Practice/skill-building is required at home.
- Caregivers manage behaviors and symptoms and PRAISE.
- Therapy is time-limited. Caregivers are the ones carrying on the torch.

Deblinger et al. (1996); Cohen & Mannarino (1996; 1997)

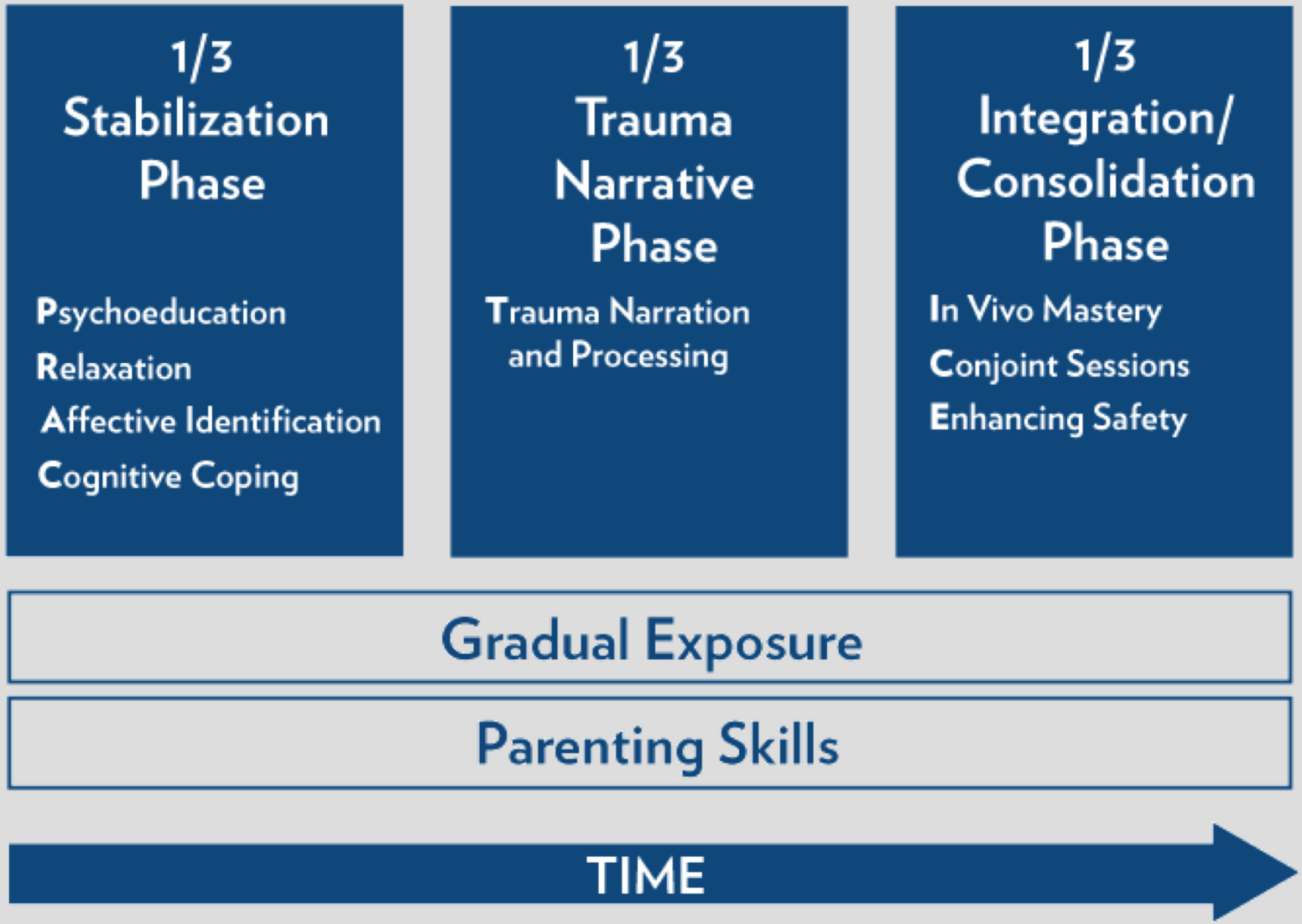
PRACTICE TF-CBT

- **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

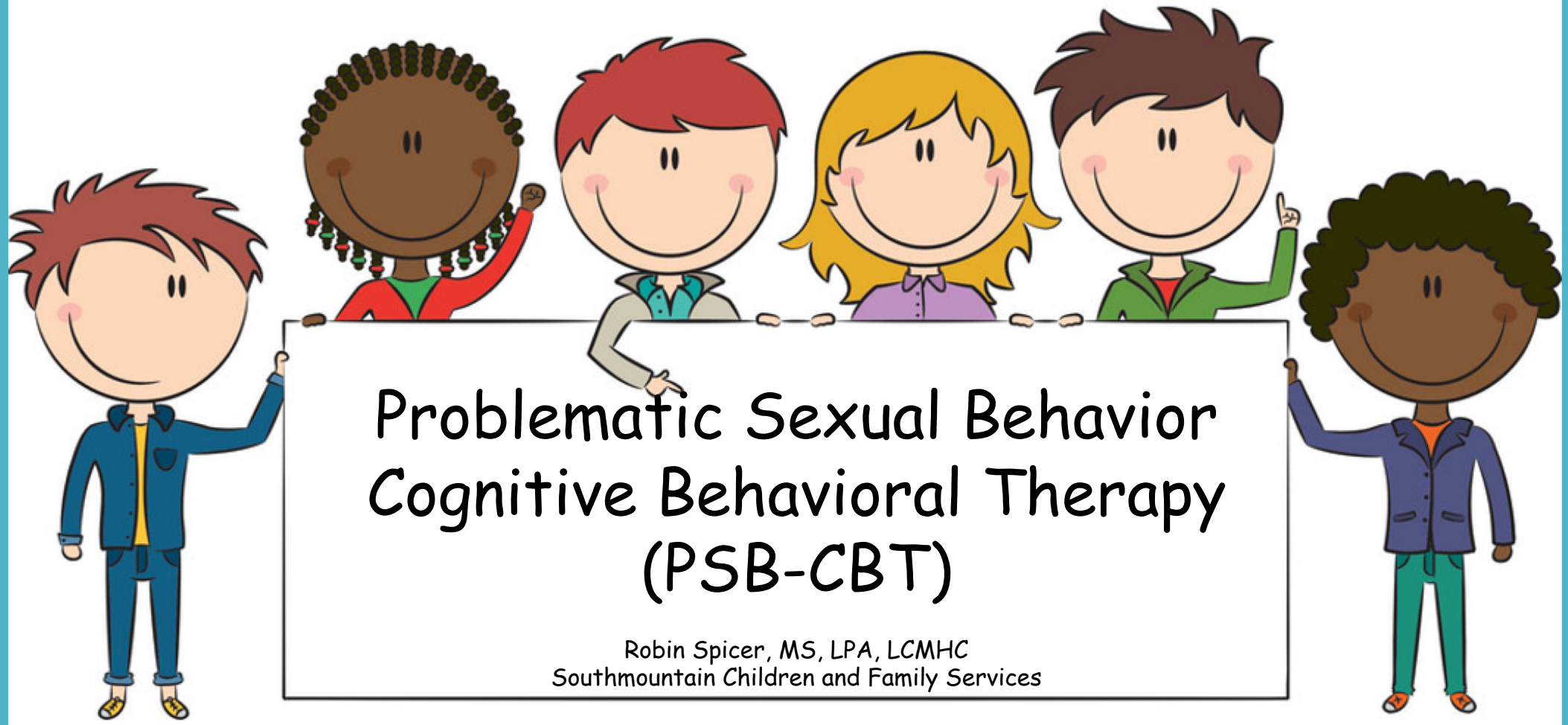




TF-CBT Pacing



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.

Nikki Croteau-Johnson, MA, LPA, Clinical Director – Problematic Sexual Behavior Program

NC Child Treatment Program Center for Child & Family Health

ORGINS 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

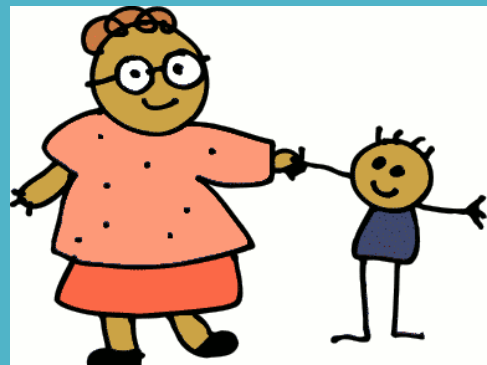
Problematic sexual behavior may exist along with:

-neglect and/or physical abuse

-exposure to violence

-exposure to sexualized environment or sexually explicit media

-substandard parenting practices



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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

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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.

Nikki Croteau-Johnson, MA, LPA, Clinical Director – Problematic Sexual Behavior Program

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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.

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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

Go to Resources

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

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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