Children are Sacred
Fact Sheet for Mental Health Providers

Understanding Problematic Sexual Behavior in Youth – A Factsheet for American Indian and Alaska Native Tribes.

Much of Native culture is based on the Circle of Life. Culture teaches us that we are all relatives to all things in creation. Healthy development of our children integrates emotional, behavioral, physical and spiritual growth.

Problematic Sexual Behaviors (PSB) are a set of behaviors that are developmentally inappropriate, potentially harmful to self or others, and could be illegal depending on a variety of factors. Mental health providers can help restore the Circle by helping youth and families.[1]

Some sexual behaviors are normal, while others are problematic. Health providers in tribal communities play important roles in identifying and providing culturally congruent effective treatment for youth with PSB, child victims and their families.

Known Protective and Risk Factors

Tribal protocol, practices and ceremonies can facilitate resilience and protective factors in youth. Protective factors that facilitate healthy behaviors and good decisions at the individual, family and community level include the following:

- Adults providing supervision and guidance throughout development.
- Healthy boundaries and coping skills that are modeled and supported.
- Protection from trauma or harm.
- Friendships with peers who make healthy decisions.
- Having experiences of competencies or success.
- Open communication about relationships and sexual matters with healthy adults.[3]

Risk factors for youth with PSB are universal and not based on any demographic, psychological or social factors. The NCSBY identified the following individual, family and community-level factors that may be helpful for understanding youth with PSB.[7]

- Sexual abuse, particularly when it occurs at a young age, involves multiple perpetrators, or is intrusive.
- Lack of information or limited accurate information about bodies and sexuality, unhealthy boundaries or privacy in the home, exposure to adults' sexual activity or nudity, pornography or other factors that lead to a sexualized environment.
- Exposure to harsh or coercive interactions, such as family or community violence, physical abuse, bullying or other factors.
- Child vulnerabilities may hinder a youth's ability to cope with stressful events or control impulses and respect the boundaries of others. These include attention deficit disorder, learning and language delays, reactions to trauma events or other factors.
- Factors that hinder a parent or caregiver's ability to monitor, guide, support and teach their children, such as depression, substance use, exposure to abuse and other factors.[3]

Establish Protocols and Procedures

- Referral and access to treatment.
- Reporting requirements, limits and maintenance of confidentiality, and collaboration with community agencies.
- Coordination of care of children simultaneously involved with other agencies, particularly child protective services and juvenile justice.
- Data sharing and tracking cases across systems.
- Planned and coordinated treatment for youth with PSB, child victims and caregivers.

Response of Problematic Sexual Behavior

- Behaviors range in their degree of severity. There is not a profile or single set of characteristics of youth with problematic sexual behavior.
- Start by assessing youth and family risk, needs, responsivity and protective factors.
- Develop supervision and safety plans in collaboration with parents/caregivers and other relevant adults, such as extended family members, school personnel, mentors, coaches and others.
- Directly include the family, particularly caregivers, in the treatment.

- Address confidentiality. Know what can and cannot be shared, and how to be respectful when sharing.
- Utilize a multidisciplinary team approach.
- Make decisions on a case-by-case basis. Consider intervention, removal, placement, notification, reporting, legal adjudication and contact restrictions with other youth.

Role of Assessment

- Clinical assessments should be completed by a degreed mental health professional who is licensed with expertise in child development, differential diagnosis, and non-sexual disruptive behavioral problems.
- Assessors should use a developmentally appropriate approach. Psychosexual assessment is not needed or appropriate for many youth with PSB.
- Assessors need to know their legal obligations for reporting child abuse and make these known to parents and caregivers.
- In most cases, an assessment may be obtained by reviewing background materials, taking a basic behavioral and psychosocial history from parents or caregivers, a basic interview with the child, and administration of one or more clinical instruments.
- Assessments are used to inform intervention, treatment planning, depositions and case plans.
- Clinical assessments are not official investigations.

Assessment Areas For Youth With PSB

- Context, social ecology and family. Focus on present and future contextual factors inside and outside of the home.
- Psychological and behavioral status. Broadly assess general behavior and psychological functioning and PSB. Prioritize concerns based on assessment results. Youth with PSB may have externalizing behavior problems, internalizing behavior problems (e.g. anxiety, depression) traumas, developmental and learning problems, conduct problems and exposure to adverse environments.
- Sexual behavior and contributing factors.
- Examine the pattern of PSB including the antecedents, behaviors and consequences.
- Clinical interviews can help with information gathering and treatment planning, but must be done in a non-threatening manner that is respectful and supportive of the youth and family. Convey the message that, while this is a serious behavior, effective intervention brings hope for healing.
- Identify youth and family strengths and resilience.
- Formal testing may help document the extent and nature of problematic sexual behavior and the effect of trauma. The Child Sexual Behavior Inventory – III measures the frequency of common and problematic sexual behaviors in youth ages 2 to 12 years.[2]
- Collaboration with the school may facilitate identification and assessment of developmental, language, cognitive, and social/emotional delays and educational support needs of the child.

Treatment of Problematic Sexual Behavior

Effective interventions include active involvement of parents or other caregivers. Effective treatment addresses safety planning, sexual behavior rules, managing child behavior, boundaries, sex education, abuse prevention skills, and child self-regulation and self-control skills. Professionals can encourage parents to talk with their children about their body, body parts, personal space and privacy beginning at 3 to 4 years of age. Treatment may also include emotional regulation skills, healthy coping skills, decision-making skills, social skills, restitution and amends.

Collaborate with the family and tribal leaders to consider utilization of traditional rites of passage, traditional healers, and restorative justice models for the treatment of problematic sexual behavior in youth, child victims and families.

Families of child victims as well as families of youth with problematic sexual behavior need treatment. Youth respond quickly to basic cognitive behavioral or psychoeducational interventions. Treatment includes teaching parents/caregivers and youth about privacy rules, sexual behavior rules, and boundary rules to reduce sexual and other behavior problems.[3, 4]

Children are Sacred
Fact Sheet for Mental Health Providers

A key component is help in addressing sex education, and to ensure the child has someone to talk to about friendship, elationships and sex. In this way, turning to peers or the internet as a resource is less likely. Treatment may include abuse prevention skills, healthy coping skills, impulse-control strategies and decision-making skills, safety plans, and social skills.

Outpatient treatment that allows the child to stay in the home and community is generally effective for youth with problematic sexual behavior. Treatment lasts between three and six months, based on changes in knowledge, skills, and behaviors of the youth. Intensive and restrictive treatments for PSB are needed for the most severe cases with significant co-morbid conditions and behaviors that are not responsive to community-based care. Professionals can help advocate for public policies that support treatment for youth with problematic sexual behavior. Use people-first language. Treat as children first. Have developmentally appropriate policies, laws and protocols. Open communication about relationships, intimacy, consent, prevention of abuse, pornography and other related topics is important.

Coordinate care across programs working with the family. Integrate care to address multiple needs. Consider embedding treatment in programs and services to address related risk and protective factors. That may include, suicide prevention, substance abuse, family resources and support, youth programming support and traditional activities.

What We Know About Youth With Problematic Sexual Behavior

- PSB in youth occurs in youth across sexual orientation, race, ethnicity or socioeconomic status.[1]
- More than one-third of sexual offenses against children are committed by other youth.[3]
- Risk for problematic sexual behavior is greatest among youth 12 to 14 years of age.[4]
- Almost half of child victims of problematic sexual behavior are under 6 years of age.[4]
- Problematic sexual behavior occurs most often between children/youth who know one another. More than 25% of PSB cases involve family members.[5]
- The recent average sexual recidivism rate for adolescents with illegal sexual behavior was less than 3%.[6]

"We stress that children are not offenders or predators; they are children and they are developing these behaviors – give them information. That is all that they need, that there is hope, they are not predators."

– Janet Routzen, Associate Judge Rosebud Sioux Tribe

Assessment & Treatment Resources

The Association for the Treatment of Sexual Abusers
www.atsa.com/pdfs/Report-TFCSBP.pdf

Indian Country Child Trauma Center
www.icctc.org/index.asp

National Center on the Sexual Behavior of Youth
www.ncsby.org/professionals

National Child Traumatic Stress Network
www.nctsn.org/

National Child Traumatic Stress Network PSB-CBT-S
www.nctsn.org/sites/default/files/interventions/psbcbt_fact_sheet.pdf

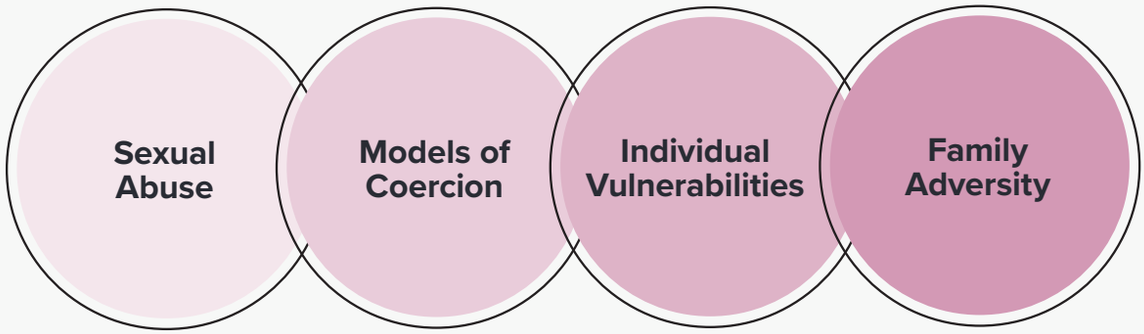
NEARI Press and Training Center Prevention For Professionals
https://nearipress.org/p4p_about/

Office of Juvenile Justice and Delinquency Prevention
www.ojjdp.gov/

U.S. Department of Health and Human Services Child Welfare Information Gateway on state and Tribal laws and policies
www.childwelfare.gov/topics/systemwide/laws-policies/state/?hasBeenRedirected=1

Children are Sacred
Fact Sheet for Mental Health Providers

Contributing Factors



Mental Health Provider Fact Sheet References

1. Silovsky, J. F., & Bonner, B. L. (2003). Children with sexual behavior problems: Common misconceptions vs. current findings. National Center on Sexual Behavior of Youth.
2. Friedrich, W.N. (1997). Child Sexual Behavior Inventory: Professional Manual. Odessa, FL: Psychological Assessment Resources, Inc.
3. Silovsky, J.F. (2009). Taking Action: Support for Families of Children with Sexual Behavior Problems. Vermont: Safer Society Press.
4. St. Amand, A., Bard, D., & Silovsky, J.F. (2008). Meta-analysis of child sexual behavior problems: Practice elements and outcomes. Child Maltreatment, 13(2), 145-166. DOI: 10.1177/1077559508315353
5. Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). Juveniles Who Commit Sex Offenses Against Minors. Office of Juvenile Justice and Delinquency Prevention, Juvenile Justice Bulletin, December 2009. Available online from: https://www.ncjrs.gov/pdffiles1/ojjdp/227763.pdf
6. Snyder, H. (2000). Sexual Assault of Young Children as Report to Law Enforcement: Victim, Incident, and Offender Characteristics. NCJ 182990. Available online from: https://www.bjs.gov/content/pub/pdf/saycrle.pdf
7. Caldwell, M. F. (2016). Quantifying the Decline in Juvenile Sexual Recidivism Rates. Psychology, Public Policy, and Law, 22(4), 414.