NCTSN The National Child Traumatic Stress Network

CULTURE-SPECIFIC INFORMATION

PSB-CBT-S: Problematic Sexual Behavior – Cognitive-Behavioral Therapy for School-Age Children

Engagement

For which specific cultural group(s) *(i.e., SES, religion, race, ethnicity, gender, immigrants/refugees, disabled, homeless, LGBTQ, rural/urban areas)* **is this treatment tailored? If none, please respond "not specifically tailored."**

The PSB-CBT-S model has been tailored for use with boys and girls from diverse backgrounds and their families. The treatment has been implemented in outpatient rural, urban, and suburban clinical settings. Currently, clinical programs are successfully implementing the PSB-CBT-S model across the United States of America and in Bristol, England. The locations of programs represent a cross section of cultural/ethnic, religious, and socioeconomic diversity. The PSB-CBT-S model has been culturally enhanced for American Indian/Alaska Native communities through the Indian Country Child Trauma Center and titled *Honoring Children, Respectful Ways* (Silovsky, Burris, McElroy, BigFoot, & Bonner, 2005; http://www.nctsn.org/sites/defaultfiles/assets/pdfs/promising_practices/HonoringChildrenRespectfulWaysHCRW_fact_sheet_3-20-07.pdf).

Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.

Clinicians trained in the PSB-CBT-S model learn how to gather culturally relevant information about families to inform engagement strategies. Sexual behavior of children and parenting are two of the most sensitive issues that can be addressed with families. Further, how families understand and respond to these topics are greatly impacted by their view of the world, personal and community norms, religion, and other cultural factors. Specific training is provided to clinicians on ways to engage families in a culturally congruent manner, recognizing the diversity found in families served. Cultural factors include level of conservatism about the topic, openness regarding sexual matters, beliefs about parenting and use of strategies such as corporal punishment, and cultural practices regarding coming of age and education on sexual topics.

Are there culture-specific engagement strategies *(e.g., addressing trust)* **that are included in the intervention?**

Acknowledging at the onset the sensitive nature of the topics and spending time listening to understand beliefs and values about parenting, sex education, and sexual behavior. Topics include determining who within their family and community are considered to be the appropriate people to talk to children about sexual behavior, including sexual education, and what knowledge is appropriate for children to learn at different ages. Clinicians should seek consultation on cultures with which they are unfamiliar, particularly when potential barriers for families are identified. For example, talking to community elders, professors of cultural studies at local colleges and universities, faith community leaders, etc.

PSB-CBT-S: Problematic Sexual Behavior – Cognitive-Behavioral Therapy for School-Age Children

Language Issues	**How does the treatment address children and families of different language groups?** The treatment can be provided in the native language of the family pending the availability of a provider who is at least bilingual in English (language of the curriculum) and the family's preferred language. Treatment materials included in the therapy curriculum are available in English and some materials are available in Spanish. **If interpreters are used, what is their training in child trauma?** (See below) **Any other special considerations regarding language and interpreters?** Given that the therapy addresses sexual behavior, special consideration should be taken regarding the vocabulary and cultural ways of talking about sexual behaviors and private body parts. If interpreters are used, then those professionals should be proficient in medical and information terminology of sexual behavior and body parts, trauma, and related symptoms. Care must be taken when using colloquial terms and examine level of mutual understanding of terms used.
Symptom Expression	**Is there research or clinical evidence to suggest that the populations served manifest trauma symptoms in differential ways? If so, are there differences in the ways that symptoms are assessed for the various populations?** There is no clear evidence that different populations manifest problematic sexual behaviors. There are differences in frequency of typical sexual behaviors found across cultures. **If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?** Guidelines are provided to examine if a sexual behavior is considered typical and acceptable, concerning, problematic or harmful. Family and cultural factors including parental concerns and wishes are integrated in the assessment process. This facilitates clinical decision-making.
Assessment	**In addition to any differences noted above, are there any differences in assessment measures used across cultural groups? If so, please indicate which measures are used for which cultural groups. Are there normative data available for the populations for which they are being used?** No culturally specific psychological measures exist to assess sexual behavior in children. Psychological measures used to assess these children are standardized and normed on samples of children of the general population of children in the United States of America. Note that sexual behavior is a sensitive topic, and measures such as the Child Sexual Behavior Inventory need to be introduced in a manner that the family can receive and understand. **If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?** Measures are used in conjunction with clinical interviews of children (starting at age 7) and their caregivers, and supplemental information and records provided by other professionals who may be involved (e.g., Child Protective Services, juvenile justice, schools, other clinicians). Measures should not be used as a sole source of information when making clinical decisions regarding children with problematic sexual behavior and their families.

Assessment continued

- The Child Sexual Behavior Inventory (CSBI; Friedrich, 1997) provides age and gender norms. Families were recruited from primary care pediatric clinics and day care centers in the Midwest and West coast. The normative sample were not children referred for concerns about sexual behaviors. The CSBI can be used with other clinical information to help with the assessment to facilitate determining if the sexual behavior is considered to be problematic or of clinical concern. A sexual behavior may be considered problematic for one of number of reasons, including that the behaviors are of greater frequency, duration than typical for their age and gender. It is important to note that the scale scores are based on frequency of the sexual behaviors. Intrusiveness, coerciveness, level of concern of individual behaviors, responsiveness to parental interventions, and level of disruption in functioning are not measured by the CSBI and would need to be examined in evaluating the child and situation. The CSBI as a measure of sexual behaviors has been found to be responsive to intervention.
- The Weekly Behavior Checklist (Cohen, J.A., & Mannarino, A.P., 1996) is a parent-report instrument particularly useful when working with preschool children and can be utilized to track progress over time on problematic sexual behavior, as well as trauma symptoms and externalizing behaviors. This is not a normed measure.

What, if any, culturally specific issues arise when utilizing these assessment measures? The use of measures with people from a culture other than that of the clinician may naturally create distrust, especially if the measures are in a language other than the client's language. Further, using measures to assess for sexual behaviors, behavioral, and emotional concerns in children could contribute to the distrust given the sensitive nature of what is being assessed. Clinicians should always strive to build and maintain trust with their clients. Further, if a challenge in communication exists due to different languages between the clinician and client, then the clinician should seek appropriate interpretation and translation services that are compliant with federal and local laws on confidentiality.

Cultural Adaptations continued

Are cultural issues specifically addressed in the writing about the treatment? Please specify. Information is available through the Indian Country Child Trauma Center (www.ICCTC.org) regarding the cultural adaptation of the PSB-CBT-S model for American Indian/Alaska Native children.

Do culture-specific adaptations exist? Please specify *(e.g., components adapted, full intervention adapted)***.** The PSB-CBT-S model has been culturally enhanced for American Indian/Alaska Native communities through the Indian Country Child Trauma Center. The program is titled *Honoring Children, Respectful Ways* (Silovsky, Burris, McElroy, BigFoot, & Bonner, 2005; http://www.nctsn.org/sites/defaultfiles/assets/pdfs/promising_practices/HonoringChildrenRespectfulWays_HCRW_fact_sheet_3-20-07.pdf).

Has differential drop out been examined for this treatment? Is there any evidence to suggest differential drop out across cultural groups? If so, what are the findings? Differential drop out has not been examined for this treatment. However, no differential dropout rates have been reported by sites implementing the treatment model.

Intervention Delivery Method/ Transportability & Outreach

If applicable, how does this treatment address specific cultural risk factors *(i.e., increased susceptibility to other traumas)***?** N/A

Is this a clinic-based treatment or is the treatment transportable *(e.g., into home, community)***? If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious?** The PSB-CBT-S model was initially delivered as a group treatment modality in a clinic-based setting. The effectiveness of the model has not been tested in any other modality or setting. However, the treatment model is adaptable to use for family therapy in the clinic or family's home.

Are there cultural barriers to accessing this treatment *(i.e., treatment length, family involvement, stigma, etc.)***?** There are no known cultural barriers to accessing the PSB-CBT-S treatment model. However, external and internal barriers to treatment exist across cultures. Depending on the location of treatment services, families may experience external barriers related to transportation, lack of childcare, competing work schedules, etc. Internal barriers may include the impact of caregivers or other family members' own trauma histories and historical trauma), strong emotions about their child following the discovery of the problematic sexual behavior, etc. Internal barriers are addressed at initial contact and throughout treatment sessions with the caregiver. The group treatment model is designed to address this by having caregivers who are further in the program providing testimony on the benefits of applying the treatment. Agencies are encouraged to address external barriers by connecting with community stakeholders and accessing resources available to families in need.

Are there logistical barriers to accessing this treatment for specific cultural groups *(i.e., transportation issues, cost of treatment, etc.)***?** Logistical barriers will vary depending on provider (e.g., billing, office location, etc.) and community factors (e.g., public transportation).

Are these barriers addressed in the intervention and how? The logistical barriers are not directly address in the intervention but rather addressed in training for the treatment providers and senior leaders on engagement of families.

What is the role of the community in treatment *(e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)***?** Community buy-in to best practices for identifying and responding to problematic sexual behavior of children and the treatment model by local community stakeholders (i.e., Child Protection Services, juvenile justice, schools, community mental health agencies, etc.) are critical to implementation of the model and long-term sustainability. These and other community leaders (e.g., faith-based, youth organizations, etc.) provide much-needed support to families regarding engagement in services and parenting a child with problematic sexual behaviors.

Training Issues	**What potential cultural issues are identified and addressed in supervision/training for the intervention?** Clinicians who are approved to provide training in the PSB-CBT-S model should receiving training and consultation on the culture of the providers being training and families served. Being able to directly address the topics of sexual behavior of children, sexual abuse, and parenting practices competently is critical. Providers whose own culture and background impacts direct discussion (such as, using anatomically correct terminology for genitalia) will need to be willing to address through training and consultation. Additionally, on-going consultation should be available for any clinical and administrative consultation provided. **If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?** Potential cultural issues between supervisor and clinician should be managed in a collaborative manner, with the supervisor taking the lead to understand the clinician's cultural background and position. Again, cultural consultation should be sought if cultural differences are such that the supervisor or clinician is unable to identify common ground from which to build or address specific cultural issues. **If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?** Training in the PSB-CBT-S model emphasizes the role and impact of culture on child development, parenting, and families' values and beliefs regarding sex and sexuality across all domains of the treatment model. **Has this guidance been provided in the writings on this treatment?** N/A **Any other special considerations regarding training?** N/A
References	Bigfoot, D. S., & Braden, J. (2007). Adapting Evidence-Based Treatments for Use with American Indian and Native Alaskan Children and Youth. *Focal Point, Research Policy and Practice in Children Mental Health*, Winter edition, 19-22. Silovsky, J. F., Burris, L. J., McElroy, E., BigFoot, D. S., & Bonner, B. L. (2005). *Honoring Children, Respectful Ways (Treatment for Children with Sexual Behavior Problems): A training and treatment manual*. Oklahoma City, OK: University of Oklahoma Health Sciences Center, Indian Country Child Trauma Center. Silovsky, J.F., Swisher, L., Widdifield, Jr., J., & Burris, L. (2011). Clinical Considerations when Children have Problematic Sexual Behavior, pp. 401-429. In P. Goodyear-Brown (ed.). *The Handbook of Child Sexual Abuse: Prevention, Assessment and Treatment.* Hoboken, NJ: John Wiley & Sons.