NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

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

Treatment Description

Acronym *(abbreviation)* **for intervention:** PSB-CBT-S

Average length/number of sessions: The treatment is provided as an open-ended group with most children able to successfully complete treatment in four to five months. The curriculum is 18 ongoing sessions.

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:** Parenting and religious values and beliefs in the context of child development, including sexual behavior, are addressed within the scope of treatment.

Trauma type *(primary)*: Children with problematic sexual behavior may or may not have a history of trauma. Sexual abuse, physical abuse, and witnessing domestic violence are traumas often found in children with problematic sexual behavior.

Additional descriptors *(not included above)***:** The OU PSB-CBT-S group treatment program is a family-oriented, cognitive-behavioral, psychoeducational, and supportive treatment group designed to reduce or eliminate incidents of problematic sexual behavior. The model can be provided to individual families when group is not an appropriate treatment modality or an option. This program involves the family or other support systems in the child's treatment and requires weekly caregiver attendance and active participation, monitoring and supporting the child's application of skills between sessions, and ongoing assessment of child progress in treatment.

Target Population

Age range: 7 **to** 12

Gender: ❒ **Males** ❒ **Females** ☒ **Both**

Ethnic/Racial Group *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)***:** OU PSB-CBT-S has been successfully implemented in the United States of America and the United Kingdom. Children and families who received treatment have come from diverse racial and ethnic backgrounds including White, African American, Hispanic/Latino, Pacific Islander, Asian, and American Indian.

Other cultural characteristics *(e.g., SES, religion)***:** OU PSB-CBT-S is appropriate for use with families of diverse socioeconomic and religious backgrounds.

Language*(s)***:** Clinical treatment is typically provided in English, though services can be provided in other languages, including American Sign Language, if providers are fluent in the primary language of the family or if an interpreter is available. OU PSB-CBT-S treatment materials are available in English.

Region *(e.g., rural, urban)***:** Urban, suburban, and rural.

Other characteristics *(not included above)***:** Caregiver involvement in treatment with the child is essential for the child's success in treatment. OU PSB-CBT-S is appropriate for children living with a variety of types of caregivers, including parents, kinship care, and foster parents. The intervention can be delivered to children in residential programs if a direct care staff member responsible for the care of the child is available to consistently attend treatment sessions with the child.

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Essential Components

Theoretical basis: Cognitive-Behavioral Therapy

Key components: Key child and caregiver clinical components of the OU PSB-CBT-S model include rules about sexual behavior and boundaries; abuse prevention skills and safety planning; emotional regulation and coping skills; impulse-control and problem-solving skills for children; developmentally appropriate sexual education; social skills and peer relationships; and acknowledgment of sexual behavior, apology, and making amends. Additional key clinical components for caregivers include behavior parent training to prevent and respond to problematic sexual behavior and other behavior problems; general child development with emphasis on psychological and emotional changes; dispelling misconceptions regarding problematic sexual behavior and implications for the child; communicating with children about sexual behavior and development; and supporting children's use of coping and decision-making skills.

Clinical & Anecdotal Evidence

Are you aware of any suggestion/evidence that this treatment may be harmful?
❒ **Yes** ☒ **No** ❒ **Uncertain**

Extent to which cultural issues have been described in writings about this intervention *(scale of 1-5 where 1=not at all to 5=all the time)*. 3

This intervention is being used on the basis of anecdotes and personal communications only *(no writings)* **that suggest its value with this group.**
❒ **Yes** ☒ **No**

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)*? ☒ **Yes** ❒ **No**

If YES, please include citation:

Biannual reports to the Oklahoma Department of Human Services

Office of Juvenile Justice and Delinquency Prevention semiannual report on Youth with Sexual Behavior Problems

Has this intervention been presented at scientific meetings? ☒ **Yes** ❒ **No**

If YES, please include citation*(s)* **from last five presentations:**

Widdifield, J.L., Jr. (October 2014). *Effective Treatment Components for Children with Problematic Sexual Behavior and Their Caregivers*. Invited preconference institute for 33rd Annual Research and Treatment Conference for the Association for the Treatment of Sexual Abusers, San Diego, CA.

Ciesar, E., Strunsky, C. & Silovsky, J. (June 2014). *Treating youth with problematic sexual behaviors in a community setting: Preliminary evaluation of a Child Advocacy Center (CAC) model for delivering evidence supported treatment*. Presentation at the 22nd Annual APSAC Colloquium, New Orleans, LA.

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Clinical & Anecdotal Evidence continued

Widdifield, J. L., Jr. (March 2013). *Children with sexual behavior problems: Current findings and implications for practice*. Invited presentation for the National Symposium on Child Abuse. Huntsville, AL.

Silovsky, J. F., Widdifield, J. L., Jr. (January 2013). *Community-based family-centered care for child sexual behavior problems*. 27th Annual San Diego International Conference on Child and Family Maltreatment, San Diego, CA.

Silovsky, J.F. & Widdifield, Jr., J. (2012, October). Children with sexual behavior problems: Current research and evidence-based treatments. Pre-conference seminar presentation at the Annual Conference of the Association for the Treatment of Sexual Abusers, Denver, CO.

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation:

Silovsky, J.F., Swisher, L.M., Widdifield, J. & Turner, V.L. (2013). Children with sexual behavior problems. In D.S. Bromberg & W.T. O'Donohue (Eds.), *Handbook of child and adolescent sexuality: Development and forensic psychology* (pp. 497-518). Oxford: Academic Press.

Silovsky, J.F., Swisher, L., Widdifield, Jr., J., & Burris, L. (2011). Clinical considerations when children have problematic sexual behavior. In P. Goodyear-Brown (Ed.). *The handbook of child sexual abuse: Prevention, assessment and treatment* (pp. 401-429). Hoboken, NJ: Wiley.

Silovsky, J.F., Burris, L., Swisher, L., & Widdifield, Jr., J. (2010). *Treatment for school-age children with problematic sexual behavior and their families: Background and program development manual*. Oklahoma City, OK: Author.

Carpentier, M., Silovsky, J.F., & Chaffin, M. (2006). A randomized trial of treatment for children with sexual behavior problems: Ten year follow-up. *Journal of Consulting and Clinical Psychology, 74*, 482-488.

Has the intervention been replicated anywhere? ☒ Yes ❒ No

Dee Norton Lowcountry Children's Center – Charleston, SC
Kristi House – Miami, FL
Children's Advocacy Services of Greater St. Louis – St. Louis, MO
Lutheran Family Services – Omaha, NE
Children's Institute International, Inc. – Los Angeles, CA

Other countries? *(please list)*
Be Safe Service, Barton Hill Settlement - Bristol, England, United Kingdom

Other clinical and/or anecdotal evidence *(not included above)*: N/A

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Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Randomized Controlled Trials	**Sample Size =** 201 (ages 6-12) 201 = children with problematic sexual behavior 52 = children with no known problematic sexual behavior (control group) **Sex of participants** 126 boys, 75 girls **Race** 154 Caucasian, 24 African-American, 11 Hispanic, Pacific Islander, or Asian, 5 Unknown	Bonner, B.L., Walker, C.E., & Berliner, L. (1999). Children with sexual behavior problems: Assessment and treatment – Final report (Grant No. 90-CA-1469). Washington, DC: US Department of Health and Human Services, National Clearinghouse on Child Abuse and Neglect. Carpentier, M., Silovsky, J.F., & Chaffin, M. (2006). A randomized trial of treatment for children with sexual behavior problems: Ten year follow-up. *Journal of Consulting and Clinical Psychology*, 74, 482-488.
Studies Describing Modifications		Carpentier, M., Silovsky, J.F., & Chaffin, M. (2006). 10 year follow-up supports cognitive-behavioral treatment for children with sexual behavior problems: Implications for services, treatment implementation, and future directions. *ATSA Forum*, 1-21.
Other Research Evidence		St. Amand, A., Bard, D.E., & Silovsky, J.F. (2008). Meta-analysis of treatment for child sexual behavior problems: Practice elements and outcomes. *Child Maltreatment, 13*, 145-166.
Outcomes	**What assessments or measures are used as part of the intervention or for research purposes, if any?** Child Sexual Behavior: Friedrich, W.N. (1997). *Child Sexual Behavior Inventory: Professional manual* [Measurement instrument]. Odessa, FL: Psychological Assessment Resources, Inc.	

Outcomes continued	Measure of Behavioral Symptoms (measures are comparable; only one should be used): Reynolds, C.R., & Kamphaus, R.W. (2015). BASC-3: Behavior Assessment System for Children [Measurement instrument]. Upper Saddle River, NJ: Pearson Education, Inc. Achenbach, T.M., & Rescorla, L.A. (2001). *Manual for the ASEBA School-Age Forms & Profiles* [Measurement instrument]. Burlington, VT: University of Vermont, Research Center for Children, Youth, & Families. Measure of trauma symptoms, such as: Briere, J. (1997). *Trauma Symptoms Checklist for Children*. Odessa, FL: Psychological Assessment Resources, Inc. Briere, J. (2005). *Trauma Symptoms Checklist for Young Children*. Odessa, FL: Psychological Assessment Resources, Inc. **If research studies have been conducted, what were the outcomes?** Results from the first comparison of the Carpentier, Silovsky, and Chaffin (2006) study, a 10 year longitudinal follow-up on the original randomized controlled trial (Bonner, Berliner, & Walker, 1999), indicated that youths who had been randomly assigned to the cognitive behavioral treatment for sexual behavior problems group had significantly fewer sexual offenses than those who had been randomized to the play therapy group (2 percent versus 10 percent). Results from the second comparison of the Carpentier, Silovsky, and Chaffin (2006) study indicated that youths who had been referred for problematic sexual behavior and treated with the CBT treatment were no more likely to commit sexual offenses than a comparison group of youths with disruptive behavior problems but no known PSB (2% versus 3, respectively). This finding suggests that the program reduced the problem sexual behavior of the treated youths to a level consistent with other youths with disruptive behaviors and no known previous problematic sexual behaviors.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Implementing the group treatment program requires a minimum of two therapy rooms, one large enough to accommodate 6-8 children and 1-2 clinicians and another for up to 10-18 adults and 1-2 clinicians. Supplies for the curriculum include basic office and arts/crafts (e.g., pencils/pens, crayons, writing paper, tape, etc.) and therapy specific, such as turtle puppets, books on sexual education, and impulse-control games. A complete list of supplies and training cost estimates is available by contacting the program at OU-YPSB@ouhsc.edu. **Supervision requirements** *(e.g., review of taped sessions)***?** See next item. **To ensure successful implementation, support should be obtained from:** Clinicians seeking to be identified as implementing the Problematic Sexual Behavior – Cognitive-Behavioral Therapy (PSB-CBT) models with fidelity must meet the following requirements for the specific age group (pre-school, school age, adolescent).

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Implementation Requirements & Readiness continued	Clinicians are encouraged to gain fidelity in conducting both caregivers' and youth's groups. Completion of these requirements and determination that the clinician meets fidelity to the model(s) is determined by a decision of the OU PSB-CBT Master Trainers. • Completed all required readings and pre-work assignments resulting from review of the exploration phase materials. • Completed the online introductory training in Trauma-Focused Cognitive-Behavioral Therapy and submitted certificate of completion provided upon completion of that training. • Attended and actively participated in the PSB-CBT intensive clinical training conducted or approved by an OU PSB-CBT Master Trainer. • Has provided the intervention for at least one year (12 months) and with a minimum of four families (i.e., caregiver and youth). • Implemented the PSB-CBT model per the treatment curriculum and with appropriate conceptualization of youth with PSB. • Actively participated in consultation calls facilitated or approved by an OU PSB-CBT Master Trainer until fidelity to the model was met. • Submitted to an OU Master Trainer(s) or an approved PSB-CBT trainer a minimum of seven recordings, audio or video (preferred), of PSB-CBT treatment sessions representative of the clinical modules for the purpose of fidelity monitoring. • Evidence of application of feedback from consultation by a Master Trainer was demonstrated. • Clinician demonstrated competence in assessing PSB families' progress in treatment and collaborated on making appropriate and informed clinical decisions about child/family completing PSB-CBT treatment services. • Clinician agreed to continue to implement the OU PSB-CBT model with fidelity and adhere to administrative decisions from OU PSB-CBT Master trainers or approved PSB-CBT trainers.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** The OU PSB-CBT-S treatment manual is only available as part of a complete training package for the model. Swisher, L.M., Widdifield, J.L., Jr., & Silovsky, J.F. (2013). Problematic Sexual Behavior – Cognitive-Behavioral Therapy: *Treatment for Ages 7-12 with Problematic Sexual Behavior and Their Families: Session Manual, 4th edition*. Oklahoma City, OK: Author. Silovsky, J.F., Burris, L., Swisher, L., & Widdifield, Jr., J. (2010). *Treatment for School-Age Children with Problematic Sexual Behavior and Their Families*. Background and Program Development Manual. Oklahoma City, OK: Author. Silovsky, J.F, Campbell, C., Widdifield, J., Bard, E., & Schwab, C. (2014). *OU Problematic Sexual Behavior – Cognitive Behavior Treatment Community Readiness Guide*. Oklahoma City, OK: Author.

Training Materials & Requirements continued	**How/where is training obtained?** Sites are encouraged to contact OU-YPSB@ouhsc.edu for more information on available training opportunities and to request a site application. Location of training is dependent on the details of the individual training project. **What is the cost of training?** Please contact OU-YPSB@ouhsc.edu for information regarding cost of training. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Clinical materials (e.g., handouts, home activities) for some treatment modules and sessions are available in Spanish (Latin American). **Other training materials &/or requirements** *(not included above)***:** Prefer clinicians have a professional license (e.g., LPC, LCSW, Ph.D.) or receiving supervision as a candidate for licensure.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** The OU PSB-CBT-S intervention is a short-term outpatient evidence-based treatment for children ages 7-12 with problematic sexual behavior, which allows most children to remain in their community and participate in treatment with their caregivers. Inclusion of caregivers in treatment services strengthens the caregiver-child relationship, increases effective parenting and behavior management skills, and enhances safety for all children, all of which support maintaining the child in the home. Provided in the open group treatment format has advantages of families being able to receive treatment services more quickly, providing support to the family, peer models for appropriate behavior, and opportunity to practice skills with others. Caregivers have reported that being with other caregivers who had already progressed further in treatment both facilitated their engagement in the program and provided needed support. Outcome evaluations provide evidence that the OU PSB-CBT-S model has a positive impact on reduction of problematic sexual behavior, non-sexual behaviors and symptoms (i.e., externalizing and internalizing), and parenting stress (Bonner, Berliner, & Walker, 1999). Further, this model directly addresses and reduces the stigma associated with having a child with problematic sexual behavior by promoting a developmental approach to serving children. **What are the cons of this intervention over others for this specific group** *(e.g., length of treatment, difficult to get reimbursement)***?** Funding or reimbursement for group based services can be difficult to obtain. Therapists implementing the model, as well as some families, may have difficulty adjusting to the open group format in which the intervention is typically delivered. Training and ongoing clinical support to address logistics of providing the intervention in an open group format and addressing child and caregiver engagement in the open group are provided to therapists during clinical training sessions and clinical consultation calls. **Other qualitative impressions:** N/A

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