Effective Treatment for Youth with Problematic Sexual Behaviors

NATIONAL CHILDREN'S ALLIANCE®

Problematic sexual behavior (PSB) is more than kids playing doctor or showing curiosity about private parts. PSB involves sexual body parts and is outside of typical development. A clear indication of a problem is when the behaviors are aggressive, intrusive, or coercive, and there is harm to the youth and others. The term is also used when youth display sexual behaviors that do not respond to parental intervention, or are frequent, intrusive, or occur among youth of disparate ages or abilities. There is hope through treatment. The first step is a clinical evaluation to examine sexual behavior, functioning, and other needs.

Best Practices for PSB Treatment for Youth

- **Developmentally Appropriate.** Therapy should be based on developmentally appropriate youth treatment models and practices, as adult offender treatment models and practices are inappropriate, ineffective, and potentially harmful.
- **Evidence Supported.** Cognitive-behavioral, skills-based and multi-systemic approaches that involve caregivers have been shown to have the best outcomes. No medication has been proven to reduce sexually abusive behavior in adolescents, but medications may help with co-occurring mental health issues.
- **Trauma Informed.** Effective treatment considers past trauma and current coping mechanisms.
- **Family Focused.** Evidence-based interventions actively involve the caregivers in treatment and address supporting the caregiver's application of effective strategies to manage the youth's behavior.
- **Least Restrictive.** With safety measures in place, most youth can receive treatment within their community. Reserve higher level of care options for youth whose behavior causes considerable risk to self or others despite community supports.
- **Minimize False Assumptions.** When a youth is exhibiting an adult-like sexual behavior, it does not necessarily mean that they have been sexually abused, or that they are on a path to life-long sexual aggression.

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

Evidence-Based Treatment Models

An evidence-based treatment model is one that has been scientifically evaluated and shown to make a significant difference in outcomes. There are currently several evidence-based treatment models for youth with PSBs (find out more at learn.nationalchildrensalliance.org/psb):

- **Problematic Sexual Behavior–Cognitive Behavioral Therapy (PSB-CBT) School-Age Program:** Children (ages 7-12; with OJJDP expansion, ages 9-14) with PSB and their caregivers.
- **Multisystemic Therapy (MST) PSB:** Youth between 10 and 17.5 years of age (and their families) when the youth has engaged in sexually abusive behavior toward others and is involved in the juvenile justice system.
- **Trauma-Focused (TF) CBT-PSB:** Children (ages 3-12) with a known trauma history who are experiencing PSBs and significant PTSD symptoms.

Effective vs. Concerning Treatment Practices

In the absence of access to mental health practitioners trained in evidence-based treatments specifically for PSB, youth may still respond to positive treatment practices. If your community cannot connect a youth with an evidence-based model, make sure that treatment practices are evidence supported and avoid ones that have been shown to be ineffective or even harmful.

Evidence-Based Practices (Do's)

DO obtain informed consent from family and assent from youth.

DO conduct comprehensive intake assessments using many sources: interviews with youth, caregivers, relatives; mental health records; police records; victim statements.

DO fully integrate caregivers in therapy, supporting their use of positive strategies, tools, and techniques.

DO provide individualized, holistic interventions with considerations for youth/family characteristics and risk/protective factors. Understand and address the impact of any previous victimization on current adjustment.

DO implement rules and limits to promote safety of the youth and others.

DO provide opportunities to practice skills and use social support in real-life situations.

DO consider the youth's physical, social, emotional, and sexual health as well as their developmental level.

DO ensure youth are in a minimally restrictive environment. Only treat outside the community if youth pose a threat to the safety of themselves or others, or due to co-occurring psychiatric concerns.

DO help youth develop self-regulation skills (behavioral, emotional, and cognitive). Focus on what they should do, not just what they shouldn't do.

Don'ts

DON'T use one-size-fits-all treatment plans.

DON'T rely on assessments based solely on information gathered from the youth.

DON'T exclude family from treatment interventions (even in residential placements).

DON'T focus solely on sexual behavior problems without addressing individual risk and protective factors.

DON'T mix populations of significantly different age, developmental level, need, and risk.

DON'T use a "no touch is the best touch" approach. Youth need to learn skills for real-life situations.

DON'T utilize adult-focused interventions, such as physiological measurements (polygraph, penile plethysmography), arousal reconditioning, aversion control (masturbatory secession), chemical/pharmacological controls (including hormonal treatment), relapse prevention cycles, or fantasy journals.

DON'T support lifetime sex offender registries for youth if the current risk is not consistent with this consequence.

DON'T promote coercive practices (fear inducing), confrontation (shame based), or punishment (shown to be ineffective at changing behavior).

For More Information

National Children's Alliance website at learn.nationalchildrensalliance.org/psb

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