Practices for the Sacred Circle:

Mental Health Providers' Guidelines for Specific Treatment Options for American Indian/Alaska Native Youth

This resource is meant to provide guidance for mental health providers as they respond to American Indian/Alaska Native (AI/AN) youth and families impacted by Problematic Sexual Behavior (PSB). The following information addresses vulnerability and protective factors identified through the **National Child Traumatic Stress Network (NCTSN)** and the **National Center on the Sexual Behavior of Youth (NCSBY)** and includes safety and supervision options with methods to develop intervention plans. These plans can be implemented in various settings, including the home, schools, and other community environments.

Treatment Plans

Treatment plans can be developed through a multidisciplinary team setting if one is available, or this task can be accomplished by therapists or other individuals working with the family. Specific roles are assigned, written and reviewed periodically by the individuals involved. The goal is to establish supervision practices for the safety of everyone involved. Plans are not static in nature but require frequent review and possible revision over time to ensure they are relevant to meet treatment goals or to reflect changes in treatment needs.

Vulnerability and Protective Factors

Vulnerabilities (also known as risk factors) and protective factors are developed for the child/teen, family members, parents/caregivers, sibling(s), peer and social factors, school and community areas, and media interactions. Siblings include other children in the home who were impacted by PSB or are at risk of being impacted. Children who are young or vulnerable and/or have a history of conflict or negative relationships require special consideration. Clinicians should pursue additional training in these areas before initiating services with children and their families. **For more information, click here**.

Treatment Plan Examples

Treatment plans will vary depending on the individual needs of the youth and their family. The following section discusses existing treatment models that can be helpful to guide treatment decisions.

Therapy for Youth with Problem Sexual Behaviors

Drs. Barbara Bonner and C. Eugene Walker and social worker Lucy Berliner developed and enhanced the original group treatment program for children with Problematic Sexual Behaviors.[1] This approach is titled Problematic Sexual Behavior - Cognitive-Behavioral Therapy™. **Multisystemic Therapy** is another type of therapy that has good evidence and many qualities that may be used for treatment with AIAN youth. Subjects in the initial research project were school-age children. TThe PSB-CBT program was evaluated through rigorous research and a 10-year follow up with law enforcement, juvenile justice, and child welfare database. PSB-CBT was more effective than a play therapy approach, with low recidivism rate of 2%.

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Therapy to Address Problematic Sexual Behavior

Problematic Sexual Behavior-Cognitive-Behavioral Therapy has been developed, researched, and implemented among youth. Practitioners at the University of Oklahoma. Children from three age groups, 3 to 6, 7 to 12, and 13 to 18, are treated using these methods.

Preschool-age children ages 3 to 6 years participate in 90-minute weekly sessions involving children and caregivers over the course of 12 weekly sessions. Topics include supervision and safety, behavior management strategies, boundaries, developing assertiveness skills, learning to make helpful choices and following rules, methods to interact appropriately with other children, and support for families. This program is provided using group and family therapy approaches. Mixed genders attend groups together.

Children ages 7 to 12 complete 60 to 90-minute weekly sessions, including the child and caregiver(s) in group sessions with other parents and children. Treatment involves 18-22 group sessions. Topics address safety and supervision, parenting strategies, sexual behavior rules and boundaries, emotional and cognitive coping skills, self-control strategies, social skills, abuse prevention, sexual education, empathy, and the impact of behavior on others. These are mixed-gender sessions.

The adolescent groups include children 13 to 18 years of age. These groups are adapted for family treatment interactions as needed. The curriculum is adjusted for youth who have successfully completed prior residential treatment. Teens who have not been seen for prior treatment for Problematic Sexual Behavior attend sessions for 12 months, while teens who have received and successfully completed prior residential treatment for these problems are treated for six months. Caregiver groups and combined teen/caregiver group interaction time is included in the treatment program.

Advanced training opportunities are available employing Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). These opportunities are focused on Problematic Sexual Behavior related to trauma experienced by preschool and school-age children. Previous completion of Trauma-Focused Cognitive Behavioral Therapy [2] is required for admission. Multiple topics are addressed, and focus areas involve parent training skills, sex education, empathy and acknowledgment, sensitivity, and addressing trauma narratives when the child has also acted out with another child. **Additional information regarding this option is available, click here**.

Several additional areas utilized for the treatment of trauma reactions have also been implemented for this purpose. They include various forms of de-conditioning and family therapy models. The reader is encouraged to review these tecāiques since they are directly applicable to the treatment of American Indian/Alaskan Native youth. However, further review of these tecāiques is beyond the scope of this toolkit.

Dolores Subia BigFoot, Ph.D., and colleagues have published culturally enhanced treatment for Adverse Childhood Experiences (ACEs) that specifically addresses trauma-informed treatment in this population.[2] These efforts are in response to the disproportional impact caused by the emotional responses to traumatic events or incidents in Native populations. Partners in these efforts have included the **Indian Country Child Trauma Center**.

Evidenced-based practices were adapted by making cultural changes in content as part of these efforts. Additional frameworks, titled Honoring Children, Mending the Circle (HC-MC) and Honoring Children, Respectful Ways (HC-RW), have been further addressed. Research in these areas is limited, and greater research efforts are required which directly involve Native researchers.

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Research involving Trauma Focused-Cognitive Behavioral Therapy is readily available on the **TF-CBT website** and through other sources. Various publications are further available for this purpose. These tecāiques are rigorously tested and address issues related to several mental health concerns and diagnostic areas. Parents have been found to benefit from these treatment efforts when they are involved with their children during treatment sessions.

Children and parents are prepared for joint sessions to occur. These sessions can involve family therapy activities. One strength of this focus is to allow elders to share previous family and tribal history and experiences that may have been lost to the youth because of boarding school experiences and other traumatic events. Healing practices and native beliefs are readily shared in the family therapy environment. This model of sharing traumatic events and related emotions becomes a good practice for generalizing disclosure of future needs.

Information so far in this resource highlights the continued growth in options to expand treatment methods for Problematic Sexual Behavior in youth. The National Center on the Sexual Behavior of Youth (NCSBY) has identified **several resources**. These areas include various service providers, ethics, gender and sexuality resources, healthy sexuality and sex education resources, internet, and tecāology safety. This includes information regarding sex, safety, and growing up with online information. The content cited is for assisting mental health professionals, youth, and parents or caregivers to understand the risks and benefits of Internet information related to sexual education. Examples include being safety conscious online and avoiding sharing personal/identifying information. References are made to sharing inappropriate communications, and the need for sharing information with trusted adults is reinforced. One example is sharing with birth relatives online when youth have little or no information regarding their history.

Expanding treatment options or methods for children and youth is another option to increase treatment availability and/or methods. An example of this tecāique is the **Good Lives Model (GLM)** of Offender Rehabilitation. Tony Ward and his colleagues developed this model. This website lists over **200 publications** representing research on these tecāiques. The model is "a strength-based approach" utilized to build strengths and capabilities in people.

Applying the GLM to youth is at an early stage, but there is emerging research in this area. It is a general rehabilitation theory with application to a wide range of offenses. This model is used internationally and in various programs, including those treating individuals with substance use disorders. Indigenous individuals who have problematic or illegal sexual behaviors have been treated using these methods, including those intellectual disabilities, teens, and adults.

Although the effectiveness of GLM has not been demonstrated in systematic studies, it remains a culturally-responsive model used in Indian Country and beyond with the treatment of youth with PSB.

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An original model was based on nine primary goods hypothesized to reflect desired outcomes people wish to obtain. These "human goods" were increased to 11 in further research and publications.

These goods are:

- Life (including healthy living and functioning)
- Knowledge (how well-informed one feels about things that are important to them)
- Excellence in play (hobbies and recreational pursuits)
- Excellence in work (including mastery experiences)
- Excellence in agency (autonomy, power, and self-directedness)
- Inner peace (freedom from emotional turmoil and stress)
- Relatedness (including intimate, romantic, and family relationships)
- Community (connection to wider social groups)
- Spirituality (in the broader sense of finding meaning and purpose in life
- Pleasure (feeling good in the here and now)
- Creativity (expressing oneself through alternative forms).

One important issue is the need to adapt the GLM to working with children displaying Problematic Sexual Behavior. Providers should be mindful that children should not be seen in isolation, there is a need to work with the family and those in their circle. This first involves understanding the difference in assisting a young person to develop a rehabilitation focus. This involves acquiring various skills, increasing the capacity for positive change, and understanding or developing a sense of personal well-being. The youth require appropriate resources to develop these and related skills.

Youth are expected to engage in these processes that have obtained varied developmental levels. This requires interviewing and potential assessments to specify the developmental levels of each child being seen in various cognitive, social, language, academic, and other areas. Various adaptations are likely to be needed to complete and validate this process. This assessment model requires further study and development before it is ready for use beyond an experimental level.

The literature provides insights into this need and process, which may be helpful. A cautionary step is to establish an initial rapport with the young person and family members to engage in the process of therapy as a team, with the therapist providing direction and suggestions. This approach can utilize Trauma Focus Cognitive Behavioral Therapy. GLM and TFCBT are two separate concepts but they can be incorporated and used together. It is helpful to adapt language, concepts, and tools necessary for adequate intervention services to be designed and implemented.

One option available in the literature developed from the GLM is G-MAP. This tecāique has structured the 11 primary goods into eight key needs and employs language more likely understood by youth. Adaptions have been developed for youth 12 to 18 years of age. This process can be repeated with young people at multiple points in time. The goal of treatment is for youth to find ways they can achieve the primary goods they want without causing harm to others or risk to themselves. Another part of this goal structure is to avoid blaming or somehow engaging in shaming them or other conditioning and other types of stigmas. The final goal of this type of therapy is for the young person to develop an individualized intervention plan for use in appropriately obtaining the human goods they desire.

This information has focused on methods to extend the GLM for use with younger American Indian/ Alaskan Native children in the future. Plans for additional research are needed to guide this process and ensure that the outcome(s) are evidence-based and able to be replicated in further research. The researchers engaged in this process should be mindful that the use of goals and supporting appropriate internal and external resources are likely to include relapse prevention and risk, need, and responsivity methods.

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Research on the Prevention of Problematic Sexual Behavior

A final area addressed in this resource involves developing specific programs for children/youth who have a potentially higher risk of displaying Problematic Sexual Behavior. Two research articles address this issue, one from Germany,[4] and the other from the United States,[5] are reviewed to address potential types of risk factors.

The first article[4] identified that a group of 12-to-18-year-old juveniles with a sexual preference for the prepubescent and/or early pubescent body of children exist as a target group for primary prevention measures and that these youth can be assessed for their sexual preferences. Most of the subjects from the study were aware of their sexual preference since adolescence. An assumption was offered that sexual preference is manifested during adolescence and remains stable during life. A critical need was identified to focus on the sexual preferences of adolescents who have presented Problematic Sexual Behavior. Addressing the sexual victimization of children by downloading, owning, and/or disseminating child abuse images was noted to be an international urgency.

The second article[5] addressed the need to prevent the onset of inappropriate, harmful, or illegal sexual behavior by adolescents toward children who are younger than them. Research subjects were sixth and seventh-grade students, and the treatment involved a randomized evaluation of prevention efforts in the school setting. Treatment was designed to increase knowledge and accuracy about Child Sexual Abuse behaviors and related legal boundaries. Another goal was to increase behavioral intentions by the subjects to avoid or prevent child sexual abuse and peer sexual harassment.

Findings were interpreted to support the use of this model for preventing Problematic Sexual Behavior. The curriculum is delivered during eight content sessions lasting about 45 minutes each. The focus of this intervention is on the older children avoiding victimizing younger peers.

References

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2. BigFoot, D. S., & Schmidt, S. R. (2010). Honoring children, mending the circle: cultural adaptation of trauma-focused cognitive-behavioral therapy for American Indian and Alaska native children. Journal of Clinical Psychology, 66(8), 847–856.

3. Zeccola, J., Kelty, S. F., & Boer, D. (2021). Does the good lives model work? A systematic review of the recidivism evidence. The Journal of Forensic Practice, 23(3), 285-300.

4. Beier, K. M., Oezdemir, U. C., Schlinzig, E., Groll, A., Hupp, E., & Hellenschmidt, T. (2016). "Just dreaming of them": The Berlin Project for Primary Prevention of Child Sexual Abuse by Juveniles (PPJ). Child Abuse & Neglect, 52, 1–10.

5. Letourneau, E. J., Schaeffer, C. M., Bradshaw, C. P., Ruzicka, A. E., Assini-Meytin, L. C., Nair, R., & Thorne, E. (2022). Responsible Behavior With Younger Children: Results From a Pilot Randomized Evaluation of a School-Based Child Sexual Abuse Perpetration Prevention Program. Child Maltreatment, 0(0).

Additional Resources

NCSBY Resources: https://connect.ncsby.org/psbcbt/psbcbt-model/research-and-outcomes

GLM Model: https://www.goodlivesmodel.com/publications.shtml

NCSBY Advanced Training for TFCBT Providers: https://connect.ncsby.org/psbcbt/advanced-training/advanced-tf-cbt-for-psb

NCSBY Finding Providers and Training: https://connect.ncsby.org/psbcbt/find-a-provider/psb-cbt-agency-map

NCSBY Treatment Models: https://connect.ncsby.org/psbcbt/psbcbt-model/treatment-models

MST-PSB: https://www.mstpsb.com/

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