



MST-PSB

Multisystemic Therapy for Youth With Problem Sexual Behavior

- **MST-PSB is a clinical adaptation of Multisystemic Therapy (MST) that specifically targets youth who have committed sexual offenses.**
- **MST-PSB is the *only* evidence based model for this population:**
 - identified on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).
 - received the highest Scientific Rating of 1 ("Well Supported by Research Evidence") by the California Evidence-Based Clearinghouse
- **Is family driven and delivered in youth's natural environment (i.e. home, school and community) by Master's level clinicians; 24/7 availability of MST-PSB clinician.**
- **5-7 months average duration of services; 3-5 families per clinician (average of 4 families at any given time)**
- **Intensive (often 3 or more sessions per week) therapy that addresses the multiple systemic factors associated with youth who commit sexually abusive offenses, including Individual, Family, Peer, Community and School factors.**
- **Maintains victim, community and client safety as the top priority.**
 - Highly individualized safety plan developed for each youth in treatment
 - Strong focus on youth's grooming behaviors (when present), family and youth characteristics related to sexual offense, community/physical environment and history of sexually abusive behaviors
 - Addresses actual and potential victims' physical, emotional and psychological safety
 - Requires caregiver buy-in and commitment to enforcing
- **Strong focus on fidelity to the model through regular supervision, consultation and training.**
 - 1.5-2 hours per week of group supervision
 - 1 hour per week phone consultation with MST-PSB expert clinicians in which each case is specifically reviewed to promote effective treatment and model fidelity
 - Ongoing supervisor support/training sessions
 - Use of model adherence measures and video-taped sessions
 - Quarterly on-site booster trainings for staff and supervisors
- **Basic components of the model include:**
 - Assessment and Evaluation
 - Safety Planning
 - Addressing Denial and Minimization
 - Grooming and Cognitive Variables
 - Clarification Work
 - Managing the Youth's Own Victimization and Trauma
 - Skills Training and Development of Pro-Social Behaviors and Peer Group
 - Reunification (when appropriate)

A. MST-PSB is a clinical adaptation of Multisystemic Therapy (MST) that specifically targets youth who have committed sexual offenses.

- MST is an intensive, community based intervention that is strengths-based and present-focused. It engages the youth's entire ecosystem in assessment, planning and intervention, and provides services at times and locations that are convenient to the family (thereby significantly increasing attendance, engagement and participation in treatment). In general, MST-PSB has a higher frequency and intensity of contacts than "regular" MST, and requires videotaping of therapy sessions to be used as a training/supervision tool and to ensure fidelity to the model.
- **The MST model is based on nine treatment principles:**
 1. The primary purpose of assessment is to **understand the fit** between the identified problems and their broader systemic context.
 2. Therapeutic contacts **emphasize the positive and use systemic strengths** as levers for change.
 3. Interventions are designed to **promote responsible behavior** and decrease irresponsible behavior among family members.
 4. Interventions are **present focused and action oriented**, targeting specific and well-defined problems.
 5. Interventions **target sequences of behavior within and between multiple systems** that maintain the identified problems.
 6. Interventions are **developmentally appropriate** and fit the developmental needs of the youth.
 7. Interventions are designed to **require daily or weekly effort by family members**.
 8. Intervention **effectiveness is evaluated continuously** from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
 9. Interventions are designed to **promote treatment generalization and long-term maintenance of therapeutic change** by empowering caregivers to address family members' needs across multiple systemic contexts. (Henggeler, et. al. 1998)

B. MST-PSB is the *only* evidence based model for this population:

- identified on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP).
- received the highest Scientific Rating of 1 ("Well Supported by Research Evidence") by the California Evidence-Based Clearinghouse

To date, there have been three randomized clinical trials of MST-PSB. The first study (Borduin, Henggeler, Blaske and Stein) involved 16 male sexual offenders and their families. Most participants had at least two arrests for sexual offenses (including rape, sexual assault and molestation) and averaged more than four arrests for sexual and other criminal offenses combined. The mean age was 14.2 years; 62.5% were White and 37.5% were African American; 69% of participants lived with one parent. Participants were randomly assigned to MST or Individual Counseling. Results of a 3-year follow up showed that 12.5% of the MST participants were rearrested for a sexual offense, compared to 75% of the control group. 25% of the MST group were arrested for other offenses, compared with 50% for the control group. None of the MST youths were incarcerated at the 3-year follow up, compared to 37.5% of the control group. (1990, International Journal of Offender Therapy and Comparative Criminology, 34, 105-114).

The second study (Borduin, Schaeffer and Heiblum) involved 48 sexually offending youth and their families. The mean age was 14 years; 66.7% were White, 33.3% African American; 70.8% lived with one parent. The study was a pretest-posttest control group design with a multi-agent, multi-method battery used to assess outcomes. The instrumental outcomes at post-treatment showed that MST was significantly more effective at decreasing behavior problems in youth, decreasing youth criminal offending, decreasing parent and youth symptoms, increasing family cohesion and adaptability, decreasing youth association with deviant peers, increasing youth emotional bonding and social maturity in relations with pro-social peers, decreasing youth aggression in relation with peers, and improving youth grades in school. Arrest and incarceration outcomes at the 8.9 year follow-up showed that MST was significantly more effective at preventing sexual offending (8.3% for MST compared to 45.8% for usual services) preventing other criminal offending (29.2% compared to 58.3%), and decreasing days incarcerated during adulthood by 80% (2009, *Journal of Consulting and Clinical Psychology*, 77, 26-37). The average costs per offender at the 8.9 year follow up, including taxpayer costs plus crime victim costs (assuming one victim per arrest) is \$47,062 for the MST group compared to \$229,852 for the “usual services” group (Klitz, Borduin & Schaeffer, 2009).

The third study, funded by the NIMH, was a Chicago-based study that examined 127 sexually offending youth. Participants were randomly assigned to the MST group or to services as usual (sex-offender specific outpatient group treatment provided by the Department of Probation). Results of the 1 year follow-up show that, relative to the “usual services” participants, the MST group evidenced reduced delinquency, reduced sexually inappropriate behavior, reduced deviant sexual interests, reduced alcohol and substance use, reduced psychiatric symptoms, and reduced out-of-home placements (2009, *Journal of Family Psychology*, 23, 89-102).

From a review of the research published in 2009, SAMHSA’s National Registry of Evidence-Based Programs and Practices identified six favorable outcomes for MST-PSB: problem sexual behavior; incarceration and other out-of-home placement; delinquent activities other than problem sexual behaviors; mental health symptoms; family and peer relations; and substance use.

Outcome 1: Problem sexual behavior

Problem sexual behavior was measured using recidivism data from court records and the Adolescent Sexual Behavior Inventory (ASBI). Findings showed that youth participating in MST-PSB had fewer re-arrests for a sexual crime than youth in the comparison group (receiving outpatient and individual treatment) during the 8.9 year follow up period (8.3% for MST-PSB compared to 45.8% for the comparison group). From the ASBI subscales, MST-PSB youth had a significantly greater reduction in problem sexual behavior from pretreatment to 12 months post-recruitment than the comparison group. The “Quality of Research Rating” for this outcome is 3.8 (0.0-4.0 scale). (NREPP, SAMHSA’s National Registry of Evidence-Based Programs and Practices, 2009)

Outcome 2: Incarceration and other out-of-home placement

This outcome was assessed using court records and Services Utilization Tracking (SUT) forms (monthly forms completed by caregivers which identified whether the youth resided outside of the home since the last assessment, and, if so, in what setting – e.g. detention, foster care, residential, etc.). Data from court records over the 8.9 year

follow-up showed that youth assigned to the MST-PSB group spent 80% fewer days in detention facilities than youth in the comparison group. Data from the SUT forms showed that youth assigned to MST-PSB were less likely to be in an out-of-home placement during the past 30 days than youth in the comparison group. The “Quality of Research Rating” for this outcome is 3.8 (0.0-4.0 scale). (Ibid.)

Outcome 3: Delinquent activities other than problem sexual behavior

This outcome was assessed using the Self Report Delinquency Scale (SRD). From pre- to post-treatment, self-reported person and property related crimes decrease among youth participating in MST-PSB and increased in youth in the comparison group. In another study, self-reported delinquent behaviors from pre-treatment to 12 months post-recruitment decreased by 60% for youth in MST-PSB, and by 18% for youth in the comparison group (who were assigned to typical offender-specific treatment). The “Quality of Research Rating” for this outcome is 3.9 (0.0-4.0 scale). (Ibid.)

Outcome 4: Mental health symptoms

Mental health symptoms were assessed using the Global Severity Index of the Brief Symptom Inventory (BSI-GSI), the Revised Behavior Problem Checklist (RBPC), the Child Behavior Check List (CBCL) and the Youth Self Report (YSR). From pre- to post-treatment, mothers, fathers and youth in the MST-PSB group had decreases in self-reported psychiatric symptoms measured by the BSI-GSI, while individuals in the comparison group had increases in these symptoms. RBPC data showed that parent-reported youth behavior problems decreased among MST-PSB youth and increased among youth in the comparison group. In another study, youth in the MST-PSB group had a significantly greater reduction in externalizing symptoms on the YSR across time, compared to youth receiving typical offender treatment in the comparison group. The “Quality of Research Rating” for this outcome is 3.9 (0.0-4.0 scale). (Ibid.)

Outcome 5: Family and peer relations

Family and peer relations were assessed using the Family Adaptability and Cohesion Evaluation Scales II (FACES-II) and the Missouri Peer Relations Inventory (MPRI). From pre- to post-treatment, self-reported cohesion and adaptability increased significantly among families participating in MST-PSB, and decreased in families in the comparison group. According to reports from youth, their parents and teachers, emotional bonding and social maturity increased among youth in MST-PSB and decreased among youth in the comparison group. Parent and teacher reports also indicated a decrease in aggression toward peers in the MST-PSB group. The “Quality of Research Rating” for this outcome is 3.6 (0.0-4.0 scale). (Ibid.)

Outcome 6: Substance use

Substance use was assessed using a subscale of the Personal Experience Inventory (PEI). From pre-treatment to 12 months post-recruitment, youth participating in MST-PSB reported a 52% decrease in substance use, while youth in the comparison group reported a 65% increase in substance use. The “Quality of Research Rating” for this outcome is 3.9 (0.0-4.0 scale). (Ibid.)

- C. Is family driven and delivered in youth’s natural environment (i.e. home, school and community) by Master’s level clinicians; 24/7 availability of MST-PSB clinician.**

MST places strong emphasis on effective and ongoing assessment of family functioning, and seeks to understand the target behavior(s) in the context in which they occur. There is strong focus on improving caregiver functioning and the affective relationship between the client and caregiver, with particular attention on improving the supervision/monitoring of the adolescent. Additionally, MST assesses and intervenes within the client's peer group, and seeks to reduce (or eliminate) the youth's association with peers engaging in negative or delinquent behaviors while simultaneously increasing the youth's participation in activities with peers who engage in developmentally appropriate, pro-social behaviors. There is strong attention given to the client's academic and social competence in school settings, which includes not only working to improve the client's overall academic success, but also on strengthening the caregiver's interaction and relationship with the school system. Finally, MST seeks to strengthen linkages with community and family supports in order to help the client/family system maintain gains made in treatment and to further develop pro-social behaviors and relationships.

The primary modalities utilized in MST are family therapy, with individual and couples therapy when clinically indicated. MST interventions utilize evidence based or well established treatment interventions, including Structural Family Therapy and cognitive behavioral therapy.

D. Maintains victim, community and client safety as the top priority.

Ensuring community safety is a primary goal of MST-PSB. A highly individualized safety plan (i.e. risk reduction and relapse prevention) is developed for each youth in treatment, with particular attention given to each youth's specific grooming behaviors (if present), family characteristics, community/physical environment, and history of sexually abusive behaviors. This safety plan not only takes into account actual or potential victims' physical safety, but their emotional/psychological safety, as well. There is particular attention given to addressing the safety of victims and younger children who live in the same home or community as the client. If there are current barriers to fully ensuring safety, the youth may need to be temporarily placed with natural resources (e.g. other family members, appropriate family friends, etc.) or some other short-term care setting (e.g. foster care), until full implementation of a thorough safety plan can be assured. Any out-of-home placements will be fully coordinated with DHS, Juvenile Probation, and other systems as relevant.

MST-PSB safety plans are more than simply a list of rules that the youth is expected to abide by. They include clearly outlined monitoring plans that specify who does what, under what circumstances, and in what manner. They outline contingencies and "next steps" to undertake if the plan is compromised in any way. They are comprehensive in that they extend across the youth's entire environment (e.g. home, neighborhood, school, larger community), and establish a built-in review process to ensure that the plan is updated and adjusted to fit changing circumstances and/or environments when necessary.

Given that adolescents who have committed sexually abusive acts are not always motivated to recognize or manage their own risk factors/triggers, caregivers and significant others in the client's natural ecology are enlisted to be active participants in the implementation and maintenance of the safety plan. Because of this requirement, it is essential that the parent/caregiver either acknowledges that their child did, in fact, engage in sexually abusive behaviors, or be genuinely open to that possibility and be willing to behave as though they have.

E. Strong focus on fidelity to the model through regular supervision, consultation and training.

All therapists will participate in group supervision on a weekly basis. Group supervision typically lasts 90 to 120 minutes and is facilitated by the Program Director. Every client and all corresponding paperwork is reviewed each week. The group format is used as a way to reinforce the MST-PSB model with each therapist and allows the therapists to have a good understanding of each case in the program (which supports improved after-hour emergency services as therapists rotate 24/7 on-call responsibilities). Additionally, the group format supports team development and cohesion, and serves as a way for therapists to address and manage possible vicarious trauma that may result from their work.

Phone consultation with MST-PSB expert clinicians (through MST Associates) also occurs weekly (at least 45 per year) and lasts one hour. Similar to group supervision, therapists receive consultation on every client every week.

Quarterly on-site booster trainings are provided for all staff; full day for clinicians with an additional half-day for supervisors.

Individual supervision is not routinely scheduled, but will occur on an as-needed basis. Examples of reasons for individual supervisions may include when the therapist needs additional support in planning or practicing an intervention, when the presenting issue is such that it is not clinically appropriate to wait until group supervision, or if the therapist is reviewing or updating their individual Therapist Development Plan (each therapist develops one that is monitored and updated frequently).

The program will also collect a series of adherence measures (at the therapist, supervisor and program level) as a tool to guide program evaluation. The adherence measures will be continuously collected with the resulting data aggregated and analyzed to inform the quality improvement process which focuses on improving model fidelity, program efficiency and quality outcomes. The fidelity and outcome data and resulting recommendations will be outlined in Program Implementation Reports every six months.

F. Basic components of the model include:

○ Assessment and Evaluation

The evaluation process (including risk assessment) is based on multiple perspectives (MST-PSB therapist and supervisor, family members, youth, probation and parole, residential treatment provider when relevant, etc.) about multiple domains of functioning (individual adjustment of the youth and family members, family and peer relations, extended family relations, academic performance, etc.) and occurs in multiple contexts (e.g., home, school, neighborhood, residential treatment setting when relevant, etc.). MST Associates is aware of no assessment instrument or tool that provides a valid assessment of risk for juvenile sexual offenders and believe that the assessment process in MST-PSB is both comprehensive and valid. In fact, it may be argued that the ecologically valid (i.e., home- and community-based) treatment milieu in MST-PSB provides the opportunity for a more intensive assessment and safety planning process.

For example, prior to beginning treatment, the MST-PSB team visits the home to provide a thorough assessment of the physical environment (e.g., sleeping arrangements, locations of family members' bedrooms, locks on bedroom and bathroom doors, etc.) to ensure that family members are safe and have meaningful physical boundaries (i.e., can

have privacy when needed and appropriate). The team also visits the school and other key settings in the community (e.g., neighborhood youth center) to assess and insure safety. It is our contention that this approach to assessment provides more valid and comprehensive baseline data from which appropriate safety and treatment plans can be developed.

As part of our broad and comprehensive approach to assessment, we sometimes (when pertinent) use the Adolescent Modus Operandi Questionnaire (Kaufman, 1994), a reliable and valid method of streamlining the acquisition of information about a youth's grooming patterns.

- Full CBE with additional sexual abuse assessment/evaluation:
 - Access to potential victims
 - Deviant sexual arousal and interests
 - History of sexually abusive behavior
 - Insight into offense precursors and risk
 - Level of self disclosure and accountability
 - Official and unreported history of sexual and non sexual crimes
 - Peer and romantic relationship history
 - Use of sexually arousing material
- Safety Planning
 - See above
- Addressing Denial and Minimization

MST-PSB addresses denial not only at the individual level, but also at the family level. The MST-PSB therapist devotes whatever time is necessary to helping family members acknowledge the youth's offending behaviors and work through various forms of denial (e.g. victim blaming, denial of harm, denial of frequency, minimization, etc.). The goal is to have the youth and their caregivers place full responsibility and ownership of the offending behaviors on the youth who committed the sexually abusive act(s). While other systemic variables may have played a role, the youth must assume complete ownership and responsibility for the abusive behavior.

- Grooming and Cognitive Variables

Clearly identifying the offending youth's modus operandi is an early goal of the assessment process. Grooming strategies (if used) are identified and shared with caregivers, as this information is used to help inform the development of the safety plan. Caregivers are supported in developing and enforcing rules that will circumnavigate the youth's particular grooming strategies as a way to ensure safety and help the youth identify and manage their patterns of behavior.

MST-PSB assesses and addresses the youth and family's attitudes and cognitive factors that may be linked with their sexually abusive behaviors. This may include the youth's views and attitudes toward women and children, their use of cognitive distortions (often associated with the various forms of denial used), any sexually inappropriate fantasies and masturbation patterns, and a lack of empathy. Strategies used to address these factors include cognitive-behavior therapy and psychoeducation.

- Clarification Work

This important aspect of treatment is a process whereby the perpetrator of the abuse takes full ownership of their behavior, makes clear that the victim was not to blame, and demonstrates empathy for their victim(s). It typically involves the identified offender reading a letter to their victim, and occurs only after the perpetrator demonstrates that they have progressed sufficiently in treatment. Ideally, it would include the offender's victim, however, this should only occur if all parties are in agreement (i.e. the victim, their therapist, child advocate, etc.). Contrary to traditional models, MST-PSB places more emphasis on supporting caregivers in providing appropriate and consistent parenting than on the youth demonstrating complete and total understanding of their behavior. Overall, there is a strong family systems approach to the clarification process, and sessions typically include the caregivers throughout the process.

Some of the content areas that are explored during clarification work include:

- Acknowledgement of the reality of the abuse.
There is less emphasis placed on uncovering every incident in excruciating detail than occurs in some models. While ownership of the prevalence, intensity and scope of the abusive behavior must be achieved, the focus of MST-PSB is on what is actually done with that information. The focus of this work is ultimately on developing a comprehensive treatment plan and understanding the "fit" of the abusive behavior.
- Understanding the "fit" of the sexually abusive behavior.
The MST process of assessing the "fit" of the target behavior is completed, with a focus on considering each of the five systems addressed in the model:
 - Individual factors (e.g. planning opportunities for offense, poor social skills, cognitive distortions, past trauma, etc.)
 - Family factors (e.g. low caregiver monitoring, poor boundaries-particularly around sexuality, ineffective family structure, high conflict, family attitudes about sexual behavior, isolated family system, multi-generational abuse, etc.)
 - Peer factors (e.g. absence of appropriate peer group, association with peers who reinforce sexually aggressive behavior, etc.)
 - Community factors (e.g. community beliefs about "manhood," high rates of crime/victimization, disengaged neighbors, etc.)
 - School factors (e.g. poor monitoring of high risk areas, poor school/caregiver relationship, lack of communication of high risk behaviors to caregivers, etc.)
- Understanding how the abuse occurred.
This involves sequencing specific incidents of sexually abusive behavior and includes antecedents, the actual abusive behaviors, and resulting consequences of the behavior. This process includes sequencing both internal variables and external events. While most traditional models focus almost entirely on individual variables, MST-PSB places stronger emphasis on what was also happening at a systemic level as well. The sequencing work would also be where grooming behaviors (if present) are identified and assessed.
- Placing responsibility for the behavior on the abusing youth, not the victim.
This component essentially represents MST principle #3 (identified above). While full responsibility for the offending behavior must be taken by the youth, MST-PSB works to help caregivers take responsibility for helping the youth behave responsibly in order to ensure that the youth does not engage in future abusive acts.
- Making amends for the abusive behavior.
Having the youth in treatment make some form of restitution to the victim (including affected family members) has therapeutic value for both the youth and their victim. It is also congruent with several MST principles (#s 3, 4, 7 and 9). While this process can be very valuable, there is strong emphasis on ensuring that the restitution process does not

violate any boundaries with the victim. Restitution is highly individualized, and would need to be agreed upon by all parties involved (including the victim, their therapist/advocate, probation, etc.).

To reiterate, the majority of clarification work is done in a family systems context, which includes the caregivers throughout the process. Some of the particular family interventions utilized include the structural family therapy tools of using enactments (i.e. having family members engage directly with each other, which gives opportunities for transactional restructuring), increasing intensity (i.e. helping to amplify the messages sent by family members; supporting them to push past system supported actions that keep the family stuck in unhealthy patterns), and using isomorphism (i.e. when problematic behaviors are maintained not only by the family's structure, but also by a similar structure in a larger system; therapists work to not only change the family structure, but also that of the larger system that helps to maintain the symptomatic cycle).

- Managing the Youth's Own Victimization and Trauma

While some treatment programs take the perspective that the majority of youth offenders have themselves been victims of sexual abuse, there is growing research to show that this is likely not the case. MST-PSB does, however, pay close attention to identifying and assessing the client's own trauma history, and intervening as necessary. As a Wordsworth program, the Sanctuary Model would be the overriding trauma-informed model used within the program, and all assessment and interventions would be conducted within a trauma informed context. Depending on the presence, type and severity of symptoms related to the client's own trauma, treatment will be tailored to fit the unique needs of the client and family system. This could impact the sequencing of interventions, depending on how the client's own trauma impacts the understanding, or "fit", of their own sexually abusive behavior(s). In some cases, youth may be referred for more specialized "victim" work once they have completed MST-PSB.

- Skills Training and Development of Pro-Social Behaviors/Peer Group

In fitting with a recovery/resiliency framework, peer development is seen as a critical element in healthy adolescent growth and development. This aspect of treatment is also critical to helping the youth and their family develop a new life trajectory that sees the youth as a healthy and safe community member. Throughout the MST-PSB treatment process, there is a strong focus on avoiding harmful labels and interventions that shame the youth and/or lead them to integrate the labels of "sex offender," "pervert," "deviant," etc. as part of their self-identity.

In keeping with this, MST-PSB helps clients understand the causes of peer estrangement and/or rejection. Interventions may focus on building various social skills, including the management of aggressive behavior, development of an improved self-identify/concept, developing sharing and cooperation skills, problem solving, conflict resolution, communication skills, etc. There is strong attention paid to helping caregivers support the youth in developing new behaviors and affording them opportunities to practice and develop new relationships. Throughout this process, the goal of community safety remains paramount, and youth are not placed in situations where community safety is jeopardized.

- Reunification

When relevant and clinically appropriate, MST-PSB actively works with youth, caregivers and all involved parties (i.e. juvenile probation, DHS, family court, child advocate, victim advocate/therapist, etc.) to achieve lasting reunification. This only occurs with the agreement of all parties, after the youth has successfully completed the clarification work briefly described above, and after a meaningful and effective safety plan has been established and implemented.