An Introduction to Multisystemic Therapy for Youths With Problem Sexual Behaviors (MST-PSB)

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Juvenile Sexual Offenders Need Treatments That Can Change the Course of Their Lives

- Males under age 18 account for 17% of all arrests for sexual crimes (not including prostitution) in the United States (Federal Bureau of Investigation, 2016)
- The offense/arrest ratio for male juveniles is approximately 25:1 for sexual crimes (Elliott, 1995)
- Juveniles with histories of both sexual and nonsexual offenses are at high risk of becoming life-course-persistent offenders (Lussier, 2017)
- Total costs of a lifetime of crime range from $1.3 to $1.5 million (Foster et al., 2006)

Juvenile Sexual Offender Treatment: Focus on the Individual Youth

- Safer Society (2009) identified 494 juvenile sexual offender programs that together treat 10,000+ youths/year in the US
- Most programs focused exclusively on altering youths' individual characteristics and are patterned after cognitive-behavioral interventions with adult sexual offenders
- Programs often use individual and group therapies and include sex-offender-specific modules (i.e., deviant arousal reduction, cognitive restructuring, empathy training, relapse prevention)
- These treatment programs usually last 12 to 24 months and are delivered in residential (44%) or outpatient settings (56%)

Juvenile Sexual Offender Treatment: Is it Clinically Effective?

- Studies (*n* = 4) examining sex-offender-specific cognitive-behavioral treatment for juveniles have failed to use randomized designs
- Even so, results from these studies are not encouraging & show only small between-groups differences in sexual recidivism & even worse outcomes for general recidivism (Dopp, Borduin, Rothman, & Letourneau, 2017)
- To date, individually oriented treatment approaches for juvenile sexual offenders have little empirical support yet continue to be widely used

Juvenile Sexual Offender Treatment: Are There Other Reasons for Concern?

- Treatment seldom adheres to the principle of least restrictive setting and is not delivered with ecological validity
- Treatment seldom considers developmental differences between juvenile and adult sex offenders
- Usual treatment bears little resemblance to effective treatments for other serious antisocial behaviors
- Concerns about potential iatrogenic effects of usual treatment abound (Dodge et al., 2006; Rhule, 2005)

Correlates of Juvenile Sexual Offending

Most studies have methodological limitations, but findings suggest that multiple risk factors are linked with youth sexual offending:

- Individual youth characteristics (e.g., internalizing and externalizing problems, atypical sexual interests, sexual abuse history)
- Family relations (e.g., low warmth, high conflict, low monitoring)
- Caregiver functioning (e.g., spousal violence, substance abuse)
- Peer relations (e.g., immaturity, involvement with deviant peers)
- School performance (e.g., poor grades, school suspension, learning disabilities)
- Neighborhood characteristics (e.g., high environmental stress, criminal subculture)

ATSA 2017Adolescent Practice Guidelines

- Adolescent sexually abusive behavior is influenced by a variety of risk and protective factors occurring at the individual youth, family, peer, school, neighborhood, and community levels. Practitioners' assessment, intervention, and management efforts must recognize the array of influencing factors.

- Interventions for adolescents who have engaged in sexually abusive behavior and who have other indicators of risk associated with delinquency should include interventions for general delinquent conduct. Those youth who do reoffend are much more likely to commit a nonsexual offense than a sexual one.

ATSA, Adolescent Practice Guidelines

- Research suggests that effective treatment interventions are characterized by:

- focusing on dynamic risk factors supported by current research;
- promoting safety while facilitating prosocial and developmentally appropriate skill development;
- using evidence-based interventions that match presenting risk and needs;
- including caregivers and other positive supports;
- addressing risk and protective factors across the adolescent's natural ecologies (e.g., family, peers, school);
- occurring in the natural environment when possible to allow the adolescent and his/her caregivers to practice skills and use social supports in real-life situations;

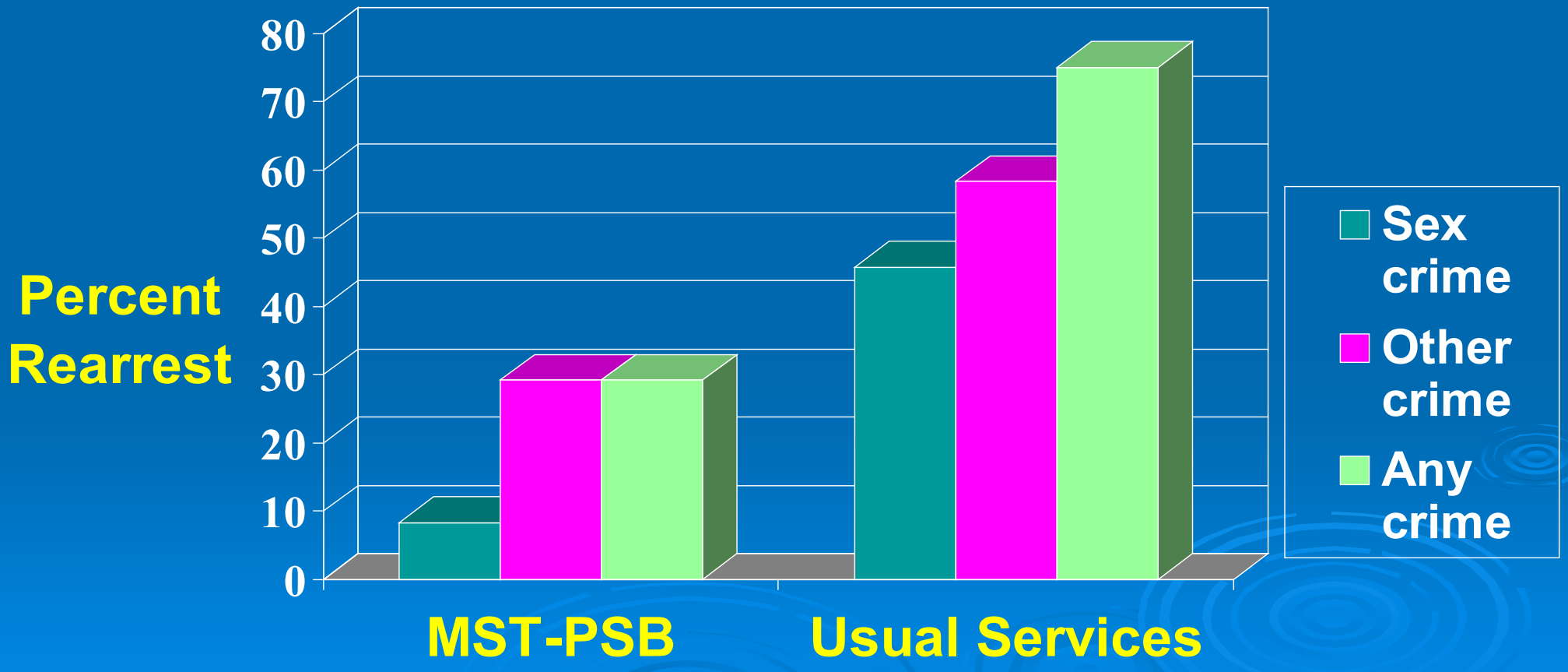
Findings from Randomized Efficacy and Effectiveness Studies of MST With Problem Sexual Behavior Youths (MST-PSB)

MST Efficacy Trials with Juvenile Sexual Offenders

- **Study 1 (1990)**
  - 16 male adolescents (*M* = 14.2 years old)
  - Randomized to MST or Individual Counseling
  - At a 3-year follow-up, MST effectively reduced:
    - Sexual reoffending (12.5% for MST, 75.0% for Individual Counseling)
    - Other criminal offending (25.0% vs. 50.0%)
    - Incarceration (0.0% vs. 37.5%)
- **Study 2 (2008)**
  - 48 male adolescents (*M* = 14.0 years old)
  - Randomized to MST or Usual Services (cognitive-behavioral group and individual therapy)
  - Instrumental outcomes: MST improved youth, family, peer, & school adjustment
  - At a 8.9-year follow-up, MST effectively reduced:
    - Sexual reoffending (8.3% for MST, 45.8% for Usual Services)
    - Other criminal offending (29.2% vs. 58.3%)
    - Days Incarcerated (by 80%)

Study 1 (*International Journal of Offender Therapy and Comparative Criminology)*
Study 2 (*Journal of Consulting and Clinical Psychology)*

Recidivism Rates at 8.9-Year Follow-Up



MST Outcomes With Juvenile Sexual Offenders

Two randomized efficacy trials with juvenile sexual offenders showed that in comparison with control groups, MST:

- **Improved family relations (i.e., more warmth, less conflict)**
- **Improved peer relations (i.e., less involvement with deviant peers, more emotional bonding with peers)**
- **Improved youth grades in school**
- **Decreased youth behavior problems & psychiatric symptoms**
- **Decreased parent psychiatric symptoms**
- **77% decrease in days in out-of-home placements**
- **Decreased long-term rates of arrest**

Does Clinically Effective = Cost Effective?

(Borduin & Dopp, 2015)

- Study examined cost-benefits to taxpayers and crime victims at 8.9-year follow-up of juvenile sexual offenders treated in Borduin et al. (2009) clinical trial
- Based on the Washington State Institute for Public Policy (Aos et al., 2001; Lee et al., 2012) Cost-Benefit Model
- This model was developed to identify ways to lower crime and lower total costs to taxpayers and crime victims
- Our estimates reflect Missouri costs to taxpayers and average national costs to crime victims

Journal of Family Psychology, 29, 687-696.

MST Benefit-to-Cost Ratio at 8.9-Year Follow-Up

The estimated benefit-to-cost ratio for MST ranges from:

$12.40 to **$38.52**

Taxpayer Benefits Only

Taxpayer & Crime Victim Benefits

That is, **$1.00** spent on MST today can be expected to return **$12.40** to **$38.52** to taxpayers and crime victims in the years ahead

24.9-Year Follow-Up

(Borduin, Quetsch, Johnides, & Dopp, 2020)

- We were able to locate 100% of the original participants (*N* = 48) who were randomly assigned to MST-PSB or usual services in the Borduin et al. (2009) clinical trial
- Average age at follow-up: 39.4 years old (*SD* = 1.9)
- Outcomes examined: criminal recidivism (felonies and misdemeanors), days incarcerated, and family abuse civil suits

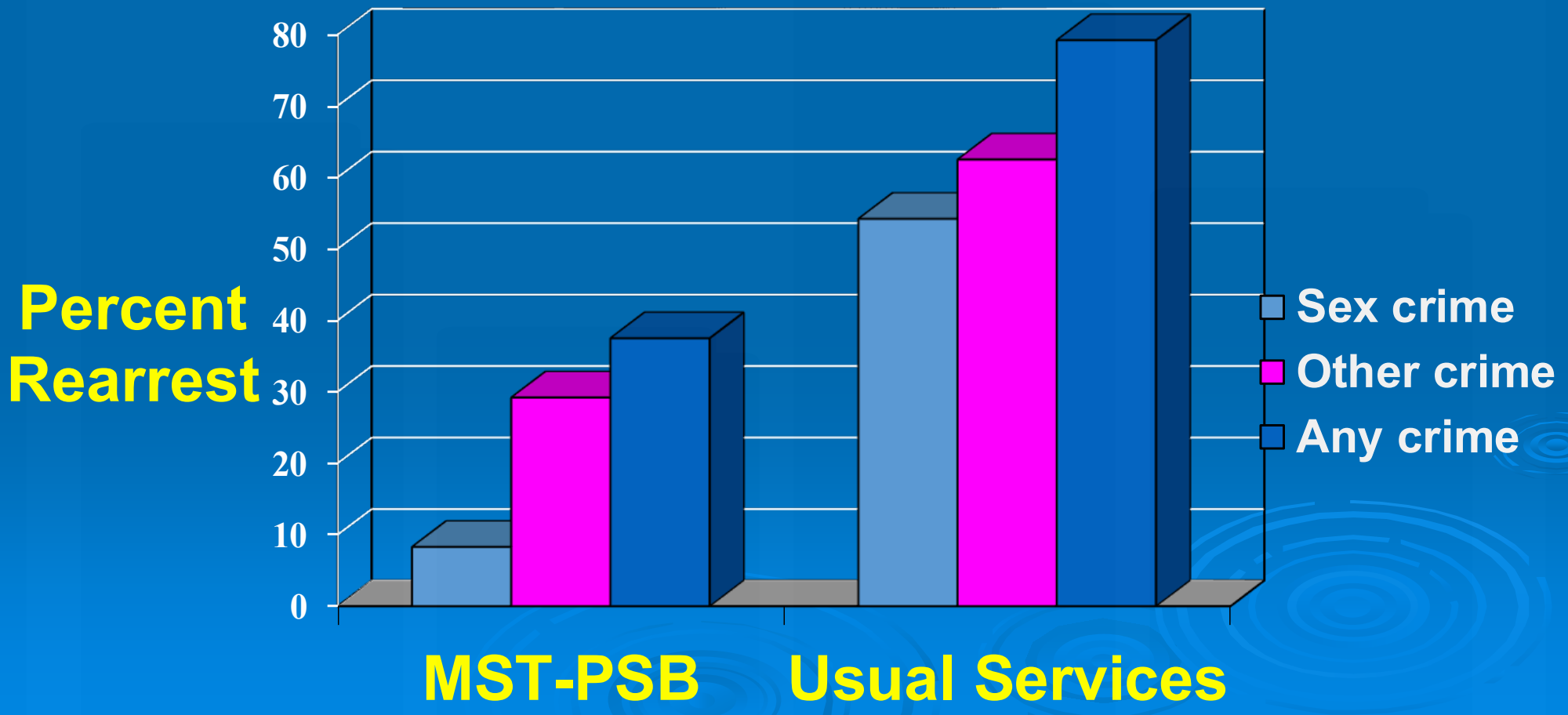
Manuscript in preparation.

Arrest and Incarceration Outcomes at 24.9-Year Follow-Up

MST-PSB was significantly more effective at:

- Preventing sexual offending (recidivism was 8.3% for MST-PSB vs. 54.2% for usual services)
- Preventing other criminal offending (29.2% vs. 62.5%)
- Decreasing years incarcerated during adulthood (by 46%)

Recidivism Rates at 24.9-Year Follow-Up



Study 3: MST-PSB Effectiveness Study with Juvenile Sex Offenders (Letourneau, Henggeler, Borduin et al., 2009)

- Examined effectiveness of MST-PSB in a usual practice setting and with a larger sample than in Study 2
- Chicago-based study with 127 juvenile sex offenders
- NIMH Funded
- Random assignment to MST-PSB or Usual Services

Results of 1-Year Follow-Up

- Outcomes: Relative to Usual Services participants, MST-PSB participants evidenced:
  - Reduced delinquency
  - Reduced sexually inappropriate behavior
  - Reduced deviant sexual interests
  - Reduced alcohol and substance use
  - Reduced out-of-home placements
- Mechanisms: MST-PSB effects on youth antisocial behavior and deviant sexual interests/risk behaviors were mediated by caregiver follow-through on discipline practices as well as caregiver disapproval of and concern about the youth's deviant friends

Outcomes article (2009): ***Journal of Family Psychology***
Mechanisms article (2009): ***Journal of Consulting and Clinical Psychology***

Results of 2-Year Follow-Up (2013)

- Outcomes: Relative to Usual Services participants, MST-PSB participants evidenced:
  - Reduced delinquency
  - Reduced sexually inappropriate behavior
  - Reduced deviant sexual interests
  - Reduced out-of-home placements

Letourneau et al. (2013): *Journal of Family Psychology, 27,* 978-985.

Some Likely Reasons for Positive Outcomes Across Three Studies

- MST-PSB targets known correlates of sexual offending in youths: individual factors, family relations, peer relations, school performance, community factors
- MST-PSB is family driven and occurs in the youth's natural environment
- MST-PSB providers are accountable for outcomes
- MST-PSB is manualized with substantial quality-assurance procedures

MST-PSB Recognition

- Blueprints for Healthy Youth Development: MST-PSB is one of 15 Blueprints Model Programs and is the only Model Program serving PSB youths
- SAMHSA - Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices
- OJJDP - Office of Juvenile Justice and Delinquency Prevention Model Program
- California Evidence-Based Clearinghouse for Child Welfare
- Early Intervention Guidebook (United Kingdom)

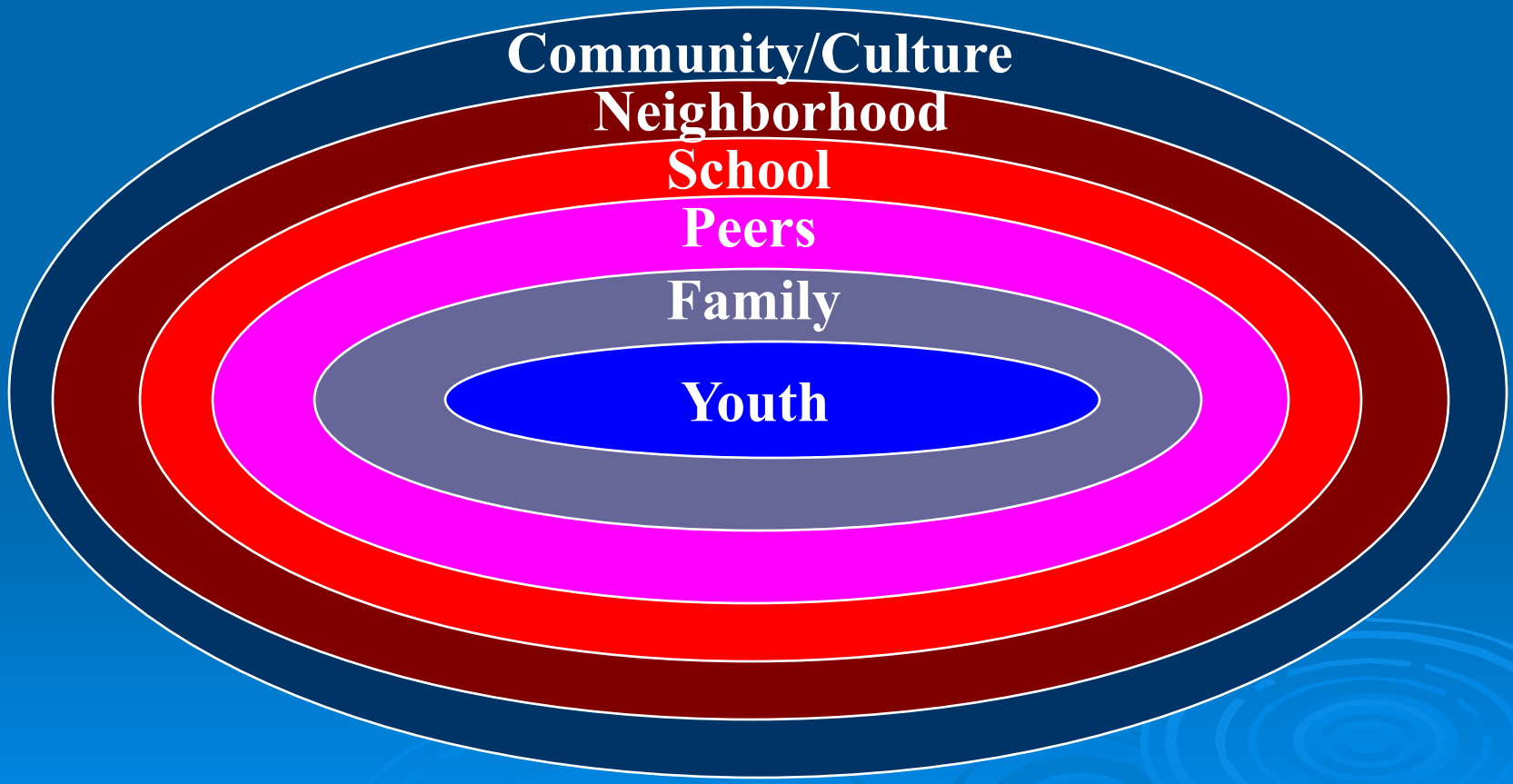
The Foundations of MST-PSB

MST-PSB is a clinical adaptation of the Multisystemic Therapy (MST) model which was designed to treat adolescents displaying delinquent behaviors

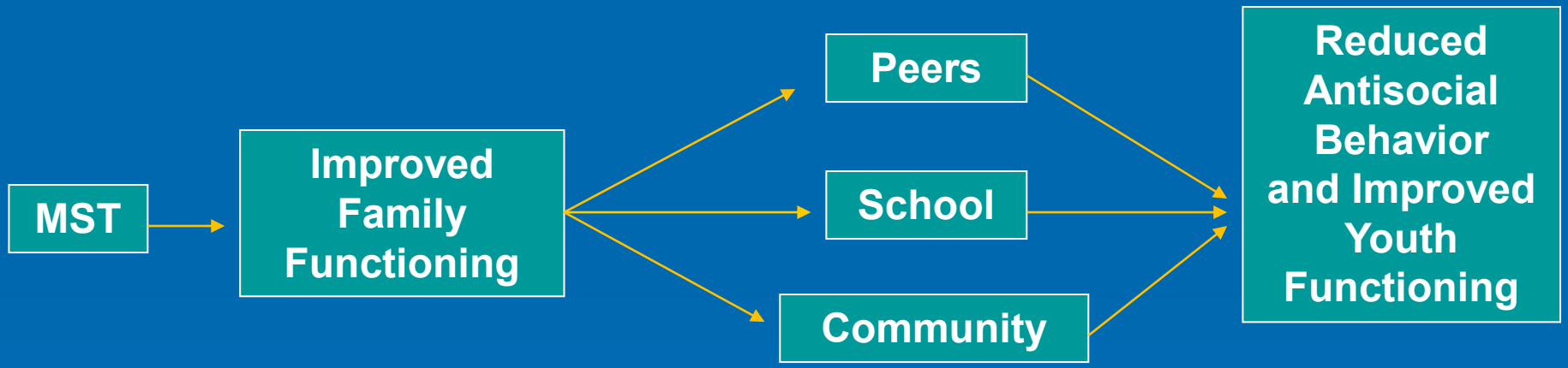
What is Multisystemic Therapy (MST)?

- An intensive family-based treatment aimed at decreasing youth problems and preventing costly out-of-home placements
- Addresses known causes of antisocial behavior comprehensively -- at youth, family, peer, school, and community levels
- Provides treatment where problems occur -- in homes, schools, and neighborhoods
- Integrates evidence-based interventions
- Views caregivers as central to achieving favorable outcomes for their youth -- resources are devoted to empowering caregivers to be more effective with their adolescents
- Uses an intensive quality assurance system to support MST program fidelity and youth outcomes

Ecological Model



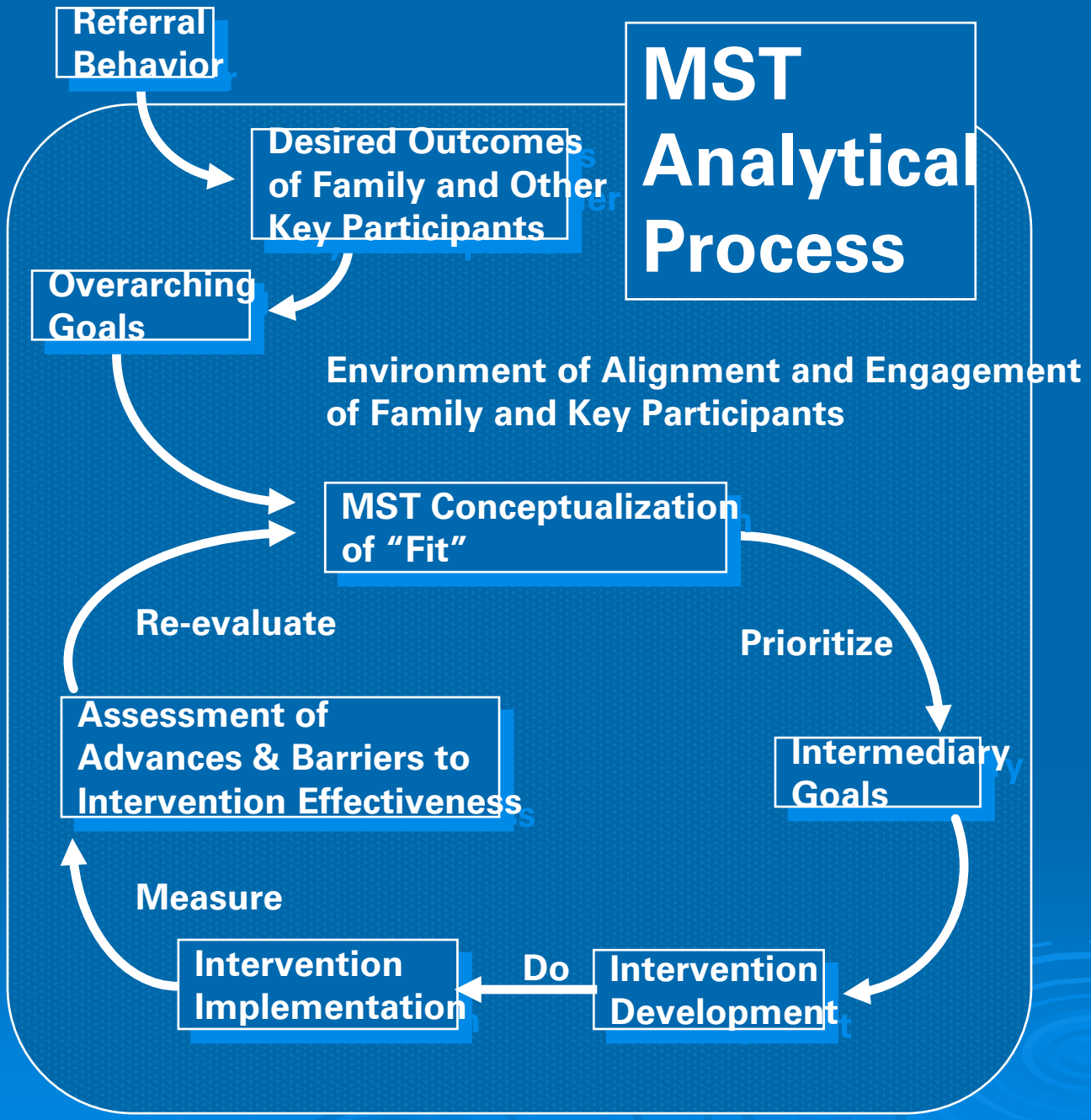
MST Theory of Change



9 Principles of MST

1. Finding the Fit
2. Positive and Strength Focused
3. Increasing Responsibility
4. Present-focused, Action-Oriented & Well-Defined
5. Targeting Sequences
6. Developmentally Appropriate
7. Continuous Effort
8. Evaluation & Accountability
9. Generalization

MST Analytical Process



How is MST Implemented?

Intervention strategies: MST draws from research-based treatment techniques

- Behavior therapy
- Parent management training
- Cognitive behavior therapy
- Pragmatic family therapies
  - Structural Family Therapy
  - Strategic Family Therapy
- Pharmacological interventions (e.g., for ADHD)

How is MST Implemented?

- Single therapist working intensively with 4 to 6 families at a time
- “Team” of 2 to 4 therapists plus a supervisor
- 24 hr/ 7 day/ week team availability
- 3 to 5 months is the typical treatment time (5 to 7 months for MST-PSB)
- Work is done in the community: home, school, neighborhood, etc.

How is MST Implemented? (continued)

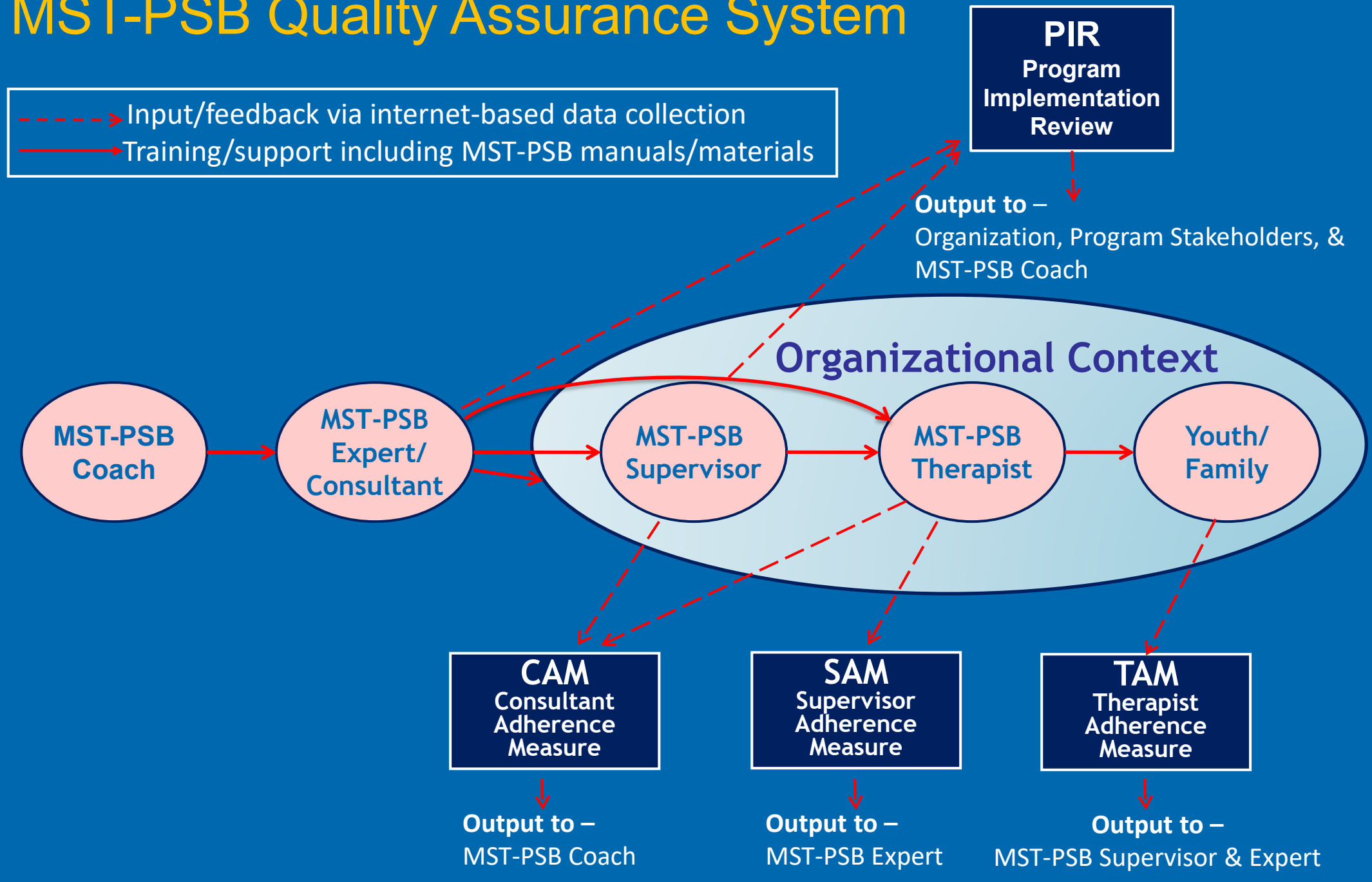
- MST staff deliver all treatment – typically no services are brokered/referred outside the MST team
- Never-ending focus on engagement and alignment with the primary caregiver and other key stakeholder (e.g. probation, child welfare, etc.)
- MST staff must be able to have a “lead” role in clinical decision making for each case
- Highly structured weekly clinical supervision and Quality Assurance (QA) processes

Dissemination of MST-PSB

Quality Assurance: Achieve positive clinical outcomes through the implementation of training and supervision protocols used in the clinical trials of MST-PSB

- Specified MST and MST-PSB treatment protocols
- Specified supervisory and consultation protocols (weekly)
- 5-day orientation training in MST model plus 2-day MST-PSB orientation training
- Quarterly booster training

MST-PSB Quality Assurance System



Comparison to Standard MST: Program Features

	MST	MST-PSB
Treatment Length	3-5 months	5-7 months*
Caseloads	4-6 clients	3-5 clients*
Stage of Development	Proactive Dissemination	Mature Transport 2nd Generation

*Results in higher frequency and intensity of service

Comparison to Standard MST: Program Features (continued)

- Site Readiness Assessment often is more involved
  - Courts/jurisdictions frequently have unique requirements
    - Psychosexual risk assessments
    - Sex offender registration
    - Augmented community supervision
  - Additional Stakeholders
    - Psychosexual Evaluators
    - Specialized Probation Officers
    - Sexual Trauma Therapists

Dissemination of MST-PSB

MST Associates: Organization focused on helping public and private agencies to achieve positive outcomes through identifying and removing barriers to effective implementation of the MST treatment model with problem sexual behavior youths (MST-PSB)

- Program structure, specification, and goals
- Site assessment and ongoing systems consultation
- Outcome measurement systems including tracking of treatment fidelity and adherence

Community-Based Dissemination Efforts: MST-PSB

* Arizona, 2 teams
* Colorado, 2 teams
* Connecticut, 4 teams
* Illinois, 1 team
* Maine, 5 teams
* Massachusetts, 1 team
* Michigan, 7 teams
* New Mexico, 5 teams
* New York, 2 teams
* North Carolina, 5 teams
* Ohio, 2 teams
* Pennsylvania, 3 teams
* Rhode Island, 1 team

* Netherlands, 4 teams

MST-PSB Target Population

- Youths 10-17 years old who have sexually offended against other persons
- May be adjudicated or non-adjudicated
- May present with other delinquent behaviors
- No exclusions for severity of problem sexual behaviors, but sites may narrow population definition via Goals and Guidelines

MST-PSB Target Population (continued)

- Same exclusionary criteria as Standard MST
  - Except problem sexual behavior is now a primary referral behavior, and
  - At least one custodial caregiver must acknowledge the problem sexual behavior and be willing to develop safety plans accordingly (any minimization or victim blaming would be a target for treatment)

Clinical Adaptations of MST for Treating Youths With Problem Sexual Behaviors

- Comprehensive safety planning to reduce risk and prevent relapse
  - Caregivers hold ultimate responsibility for monitoring and managing the youth's behavior
  - Each plan is uniquely designed to fit characteristics of the youth, his/her offense, the family, and the physical environment
  - Includes a built-in review process to adjust components (levels of monitoring, changes in ecology, discovery of new information) and ultimately be geared toward normative development
  - Should extend across the youth's social ecology (home, neighborhood, school, larger community)

Clinical Adaptations (continued)

- Addresses denial/minimization, including comprehensive family-based clarification work
  - Typically initiated in sessions involving caregivers and youth
  - Includes a sequencing process in which the youth provides a detailed account of his/her offending behavior, including both internal and external events
  - Strong emphasis placed on creating a family environment that will provide ultimate support for the victim
  - Sessions with the victim (a) occur only after the PSB youth and caregivers have completed clarification work and (b) ideally include the victim's therapist as an advocate/support for the victim

Clinical Adaptations (continued)

- Requires knowledge base in adolescent and family sexuality
- Heavier utilization of structural and strategic family therapy than in standard MST
- Thorough evaluation of any grooming process and cognitive variables that contribute to offending

Clinical Adaptations (continued)

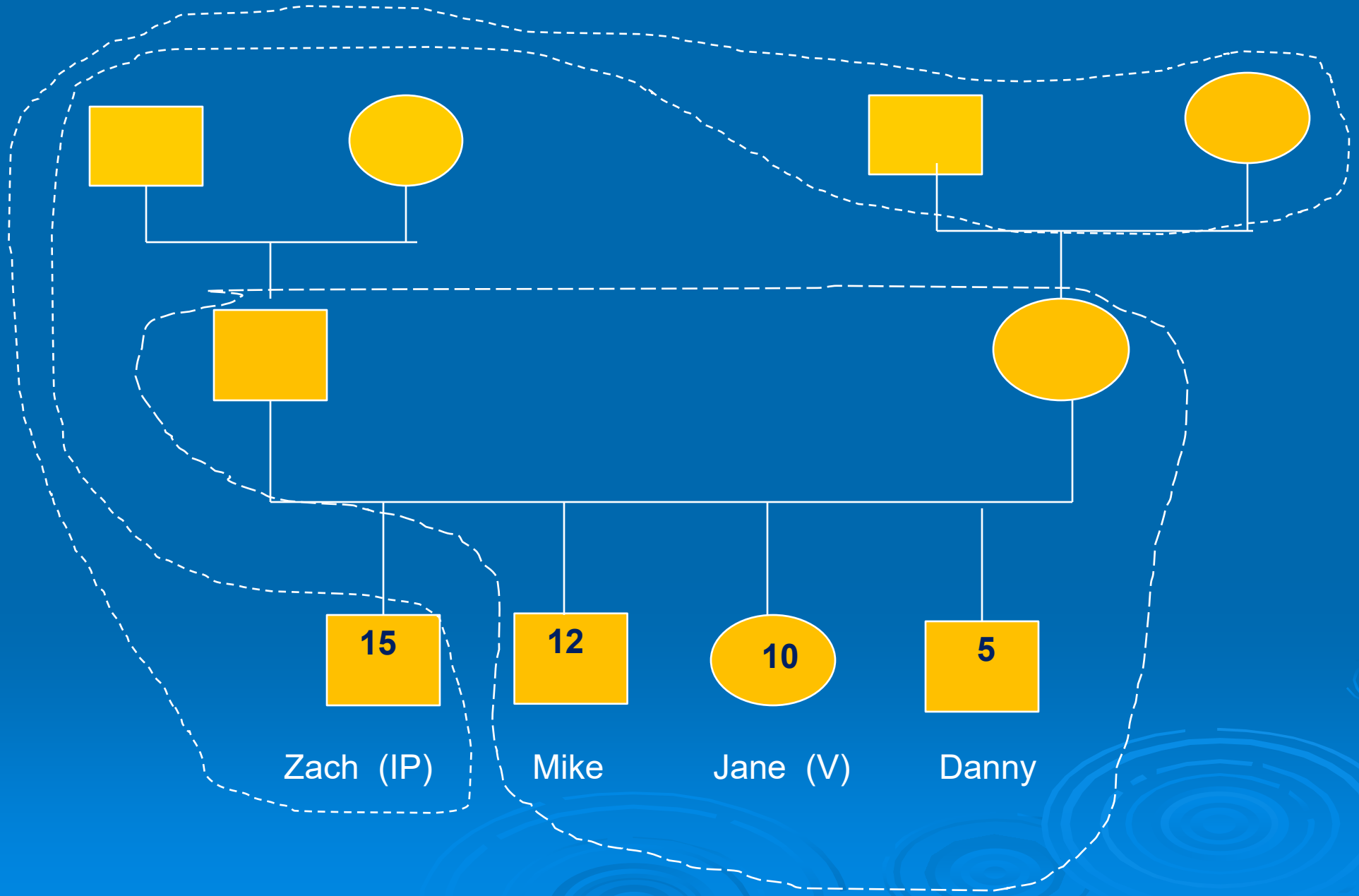
- Emphasizes development of social skills and friendships
- Addresses sexual trauma impact within family, including the youth's own victimization, and uses trauma sensitive interventions
- Videotaping of therapy sessions used as training and supervision tool

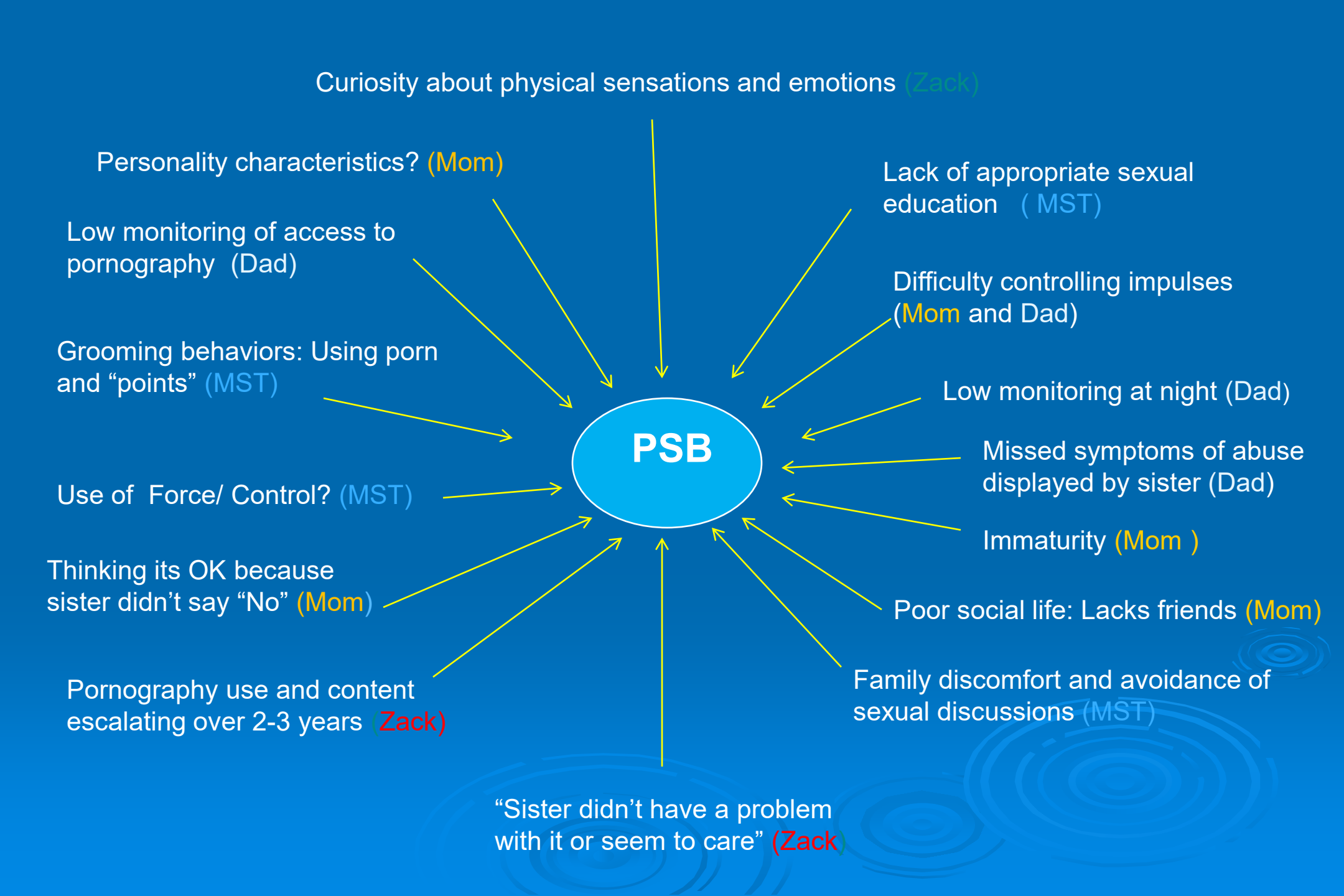
Case Example: The Baileys

- This case involved incest: Many PSB cases do not
- A “moderately difficult” case; more complex cases typically involve a wider range of antisocial and other problem behaviors
- Helps to highlight a wide range of interventions

Referral Behaviors

- Sexually abused younger sister (fondling, oral sex, intercourse) approximately once a week for 2-3 years
  - Escalation of PSB was revealed during course of treatment
  - Increased coercion/manipulation
  - Increased concealment efforts
- No other antisocial behaviors or academic problems
- Legal Status: Charged with indecent assault, rape, and committing involuntary sexual intercourse
- On probation


15
12
10
5
Zach (IP)
Mike
Jane (V)
Danny


Curiosity about physical sensations and emotions (Zack)
Personality characteristics? (Mom)
Lack of appropriate sexual education (MST)
Low monitoring of access to pornography (Dad)
Difficulty controlling impulses (Mom and Dad)
Grooming behaviors: Using porn and "points" (MST)
Low monitoring at night (Dad)
PSB
Missed symptoms of abuse displayed by sister (Dad)
Use of Force/ Control? (MST)
Immaturity (Mom)
Thinking its OK because sister didn't say "No" (Mom)
Poor social life: Lacks friends (Mom)
Pornography use and content escalating over 2-3 years (Zack)
Family discomfort and avoidance of sexual discussions (MST)
"Sister didn't have a problem with it or seem to care" (Zack)


Zack holding things in
Afraid of what parents will think of me
Since I had already been dishonest, not sure how to deal with telling truth
Unsure of what to do and how things will turn out: Want to be sure of things
I get nervous, caught off guard; I freeze up especially about involving brother Mike
Sometimes it's easier to avoid conflict
Afraid of how parents will react: Don't want consequences (especially unknown ones)
Realizing that something I hadn't given much thought to was worse than I thought (re: brother Mike)
Disappointed with myself
Can't share if I'm unsure or not thinking clearly
Trying to avoid facing negative self labels
Afraid I won't have the right to ask for things anymore

Sequencing/Clarification

Barriers/potential barriers

- Mom's minimization
- Mom's victim blaming
- Youth's initial lies/denial
- Youth's reluctance to talk
- Anxiety (for everyone)
- Youth's shame/guilt
- Family discomfort discussing sexual matters
- Dad's sexual trauma history

Sample interventions

- Always: Get Fit First
- Developing trusting atmosphere
- Pacing: Starting with less anxiety producing topics
- Using anchored anxiety scale
- Time outs when needed
- Anxiety reduction interventions
- Leveraging Dad's history
- Isomorphic messages and metaphors
- Collateral data

Sequencing/Clarification

Barriers/potential barriers

- Emerging anger from caregiver
- Family desire to quickly "get back to normal"

Sample interventions

- Facilitating healthy communication skills
- Utilizing enactments
- Achieving intensity
- Maintaining strength focus
- Focusing on youth's in-the-moment behavior
- Validation
- Instilling hope
- Humanizing victim

Lessons Learned and Some Policy Directions

1. Effective treatment for this population differs significantly (i.e., home- and family-based; 24/7 availability of therapists) from the status quo

2. Funding for the provision of evidence-based treatments must be competitive (because treatments of no or unknown effectiveness can be more profitable to providers)

3. Significant funding must be provided for training in evidence-based treatments and for ongoing quality assurance (funding and training without continuous quality improvement do not guarantee clinical outcomes)

Lessons and Policy Directions -- continued

4. Performance contracts can be used to promote accountability, outcomes, and use of evidence-based practices (clinicians and programs need to be rewarded for their success in achieving desired clinical outcomes)

5. The widespread transport of evidence-based treatments for this population will likely require collaboration among multiple levels of government and practice

Questions or More Information

Research Related:

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