GUIDE TO TREATMENT SERVICES

Welcome to the Professional Therapeutic Community Network, Inc (PTCN). Your journey to this point has been more than likely very difficult and painful. Coming to grips with the beginning realities of sexual abuse is hard and a path that we can walk with you throughout your work in treatment. You've probably wondered whether you're on the right track or that maybe this problem will just go away by itself. You may have tried many different ways to solve this problem or concern and it hasn't worked. Sometimes it seems like its getting worse. Or maybe you think that others are just making too big a deal out of nothing. Maybe you feel as though your child has been unfairly treated and "if people will just let you be" it'll get better by itself.

Parents and kids have many thoughts just like these and what we've learned at PTCN is that there is no quick fix to sexually abusive behavior problems, especially when there are other problems occurring at the same time. These other problems might be:

- Fire-setting,
- Bedwetting,
- Attachment problems,
- Conduct problems that usually involve hurting other people nonsexually,
- Care little about other people,
- Defying authority,
- Low intellectual functioning,
- Struggle dealing with the hurt other people have done to them in some cases this is called Post Traumatic Stress Disorder, and
- Divorce.

PTCN understands that this situation can feel overwhelming but we are willing to work with you to help you change your life and assist your family in overcoming the obstacles involved in the assessment and treatment process.

What is Sexual Abuse?

Sexual Abuse or Offending is the use of one's power, position, or tactics to coerce someone into sexual acts that under normal circumstances they would not do or allow to be done to them. Coercion is the use of some type of force to persuade someone to do something they don't want to do. In treatment we refer to some offenses as Hands-On and Hands-Off. Hands-On are those sexual offenses that involve touching another person (molesting, oral and anal sex, etc…). Hands-Off are those offenses that involve no touch (peeping on someone nude, exposing genitals, masturbating with someone's underwear, etc…) PTCN

takes sexual abuse seriously and is committed to reducing your risk to reoffend and maintaining community safety.

BRIEF PROGRAM OVERVIEW

Professional Therapeutic Community Network (PTCN) is a community-based organization committed to meeting the needs of individuals who have range of serious mal-adaptive behaviors. PTCN employs an Intensive Therapeutic Proctor Home model supported by a comprehensive Master Service & Treatment Plan and a team of highly-trained Proctor Parents, Skills Trainers and Therapists.

PTCN's treatment program uses a proprietary tracking system to monitor the youth's movement through trauma informed ***Neuro-Developmental Stages***. Daily tracking enables the targeting of specific developmental tasks which need to be addressed to ensure client progress and resolve ineffective coping strategies. PTCN believes that people with the most severe mal-adaptive behaviors can be integrated into positive community settings, and that the levels of support should balance individual needs with community safety.

PTCN's highly-trained Therapists, Skills Trainers and Proctor Parents accomplish this by actively integrating the individual and his supporting family, culture, level of development, and learning style. The members of PTCN's therapeutic community work to support each other and to insure the best outcomes for the youth and families they serve. We network with the community to provide continuity of care in all domains of the youth's life to enhance treatment and motivate change. We strive for integrity in all domains of the youth's growth and development.

PTCN's INTENSIVE THERAPEUTIC PROCTOR HOME MODEL

PTCN's therapeutic proctor care is a ***hybrid of several models*** described in the literature. PTCN's experience showed that the unique population it serves requires a specialized approach for service delivery and proctor care. PTCN's "therapeutic parent model" development began with the adoption of the generic client-centered therapist characteristics considered "necessary and sufficient" (Rogers, 1957) for therapeutic change that were common to all successful therapies regardless of orientation while avoiding the characteristics of abusive parents (Shealy, 1995). Under these guidelines caretakers were taught to demonstrate acceptance, empathy, and understanding while avoiding hostility, criticism, and mixed messages. However, many of these therapist characteristics that were put forth more than forty years ago (Rogers, 1957) are still considered "necessary," they are no longer considered "sufficient" in and of themselves.

Over the years, therapeutic interventions have become more refined and specific as a result of the many advances in psychotherapy and behavioral intervention which directly relate to parenting problem children. Research revealed that generic training and treatment approaches cannot be equally effective without modification to address specific disorders

(e.g., Casey & Berman, 1985). Recent abuse-specific treatments addressing the internalizing reactions of child victims (e.g., Cohen, Mannarino, Berliner, & Deblinger, 2000) and the externalizing reactions of youth abusers (e.g., Chamberlain & Reid, 1998; Henggeler, Schoenwald, & Pickrel, 1995) began to be integrated into specialized proctor care.

The Forensic Proctor Care Model was developed to address the needs of youth who externalize their childhood trauma through multiple forms of abusive behaviors. The model integrates abuse treatment techniques into caretaker training and youth behavior treatment plans. This model was outlined in The Treatment of Multiple Abuser Youth in Forensic Foster Care: A Social Responsibility Therapy Program Description. Author: Yokley, J. (2002) and discussed in The Sex Offender, Volume 4, Chapter 21. B. Schwartz (Ed.), Kingston, NJ: Civic Research Institute.
Research indicates that Forensic Proctor Care is the most functional family treatment setting and is most conducive to helping youth with a history of abusive, mal-adaptive, and delinquent behavior.

PTCN matches a youth with specialized placement and treatment to provide the least restrictive treatment environment while managing community safety for youth who exhibit abusive behaviors. PTCN's Proctor Parents are an integral part of a treatment team of specialists who provide an integral part of the therapeutic community treatment approach throughout the week.

PTCN's Proctor homes are run by well-trained professional proctor parents who work exclusively with this population of youth. Because of their specialized training, duties and experience, they are termed Proctor Parents or Proctor Families. For many, this is a full time career for the demands of the youth PTCN serves is high. The proctor home environment is highly structured, with clearly outlined rules, expectations, and daily routines and schedule of activities. The Proctor Parents of these homes participate in clinical treatment groups weekly—helping to integrate the youths' treatment needs with daily living situations. As PTCN Proctor Parents support their youth during the week they are supported in this difficult work by PTCN's therapeutic community 24/7 through:

- Clinical Consultation that is scheduled 2 times a week,
- 24 hr phone consultation to Therapists,
- Skills Trainers providing in-home supports in crisis situations,
- Community Group Meetings with the entire PTCN staff and Proctor Homes, and
- Emergency Crisis Back-up Care,
- Routine Respite Care.

The following chart compares the three basic models of foster care that PTCN combined directed towards different types of care.

	Regular Foster Care	Therapeutic Foster Care	Forensic Proctor Care
Age	*66% are under age 13*[1]	*66% are under age 13*[1]	*100% are 13 and older*
Population Served	*Primarily serves neglected and dependent children*[2] *with home environment problems*[5]	*Primarily serves victims*[3] *of abuse (most are female) with internalizing*[4] *and adjustment problems (e.g., PTSD, depression, anxiety, withdrawal)*	*Exclusively serves youth offenders (most are male) with externalizing, conduct problems (e.g., abusive behavior, dishonesty, defiance, aggression)*
Focus	*Has strong family support focus*	*Has strong child support and protection focus*	*Has strong community protection focus*
Treatment	*Child and parents are the "clients"*	*Child is the "client"*	*Both youth & community are the "clients"*
Clients	*Treatment is optional as Needed*	*Treatment is provided separately from foster care typically by a general practitioner in weekly Community Mental Health Center visits*	*Proctor parents are an integral part of a treatment team of abuse specialists who provide the therapeutic community treatment approach throughout the week*

Reproduced from - "The Treatment of Multiple Abuser Youth in Forensic Proctor Care: A Social Responsibility Therapy Program Description", Table 21-1 in Chapter 21 of The Sex Offender, Volume 4. Kingston, NJ: Civic Research Institute, B. Schwartz (Ed.)

THERAPEUTIC COMMUNITY MODEL

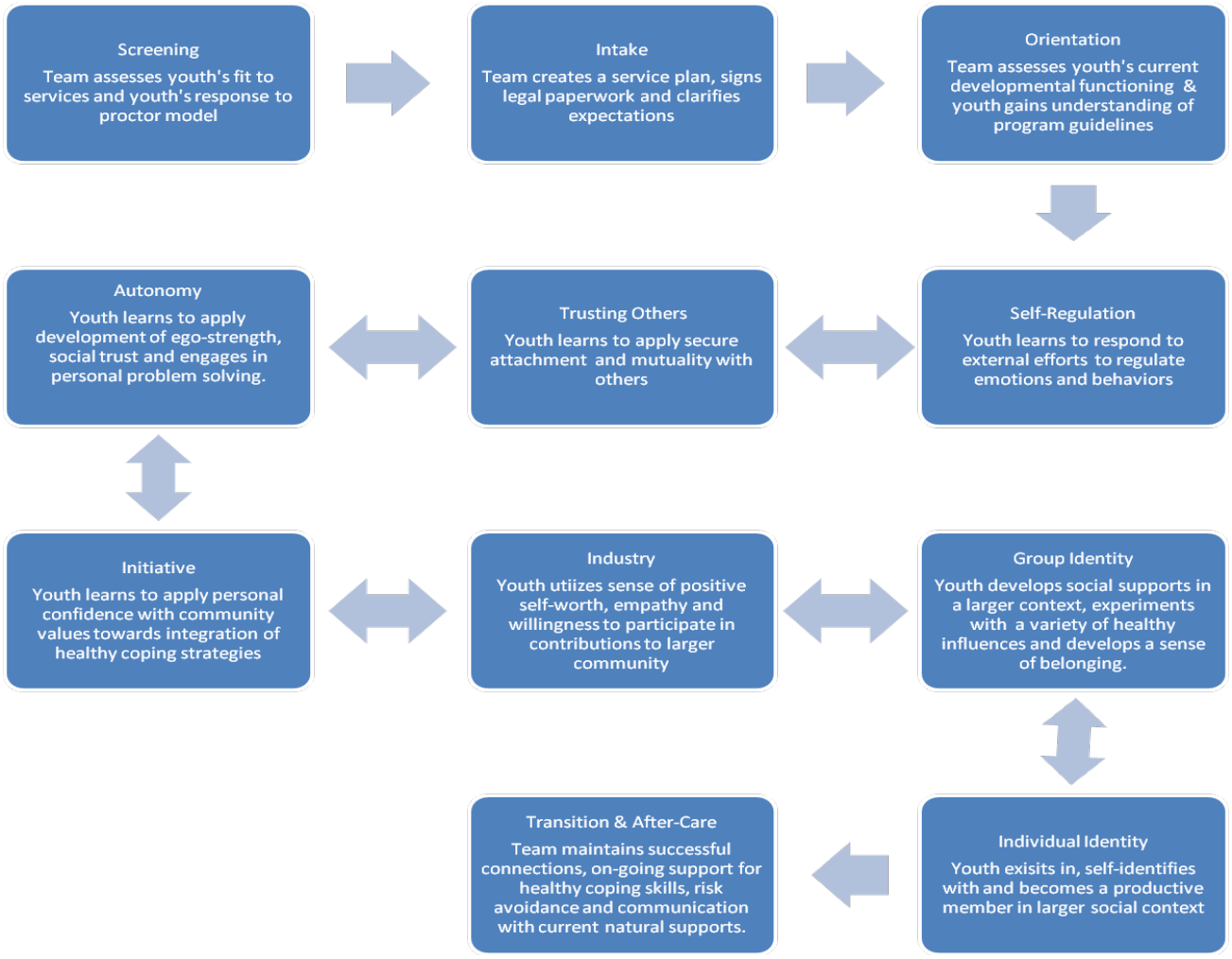
PTCN has created a therapeutic community setting for its program. This therapeutic community is built around a ***multi systemic approach*** to intervening in serious behavior problems. The therapeutic community is dependent upon the nurturing of a positive peer culture whereby youth and families support each other in growth promoting ways. The therapeutic community relies on multiple modes of intervention and service types.

Therapists, Skills Trainers, Proctor Parents, youth, family-of-origin, community partners and the other PTCN staff work together and support one another to help youth and families experience real-life change and ***develop healthy attachments***. This works because of a tremendous integration of duties and responsibilities. The chart below illustrates one example among many of the cooperation and planning that characterizes PTCN's therapeutic community.

TREATMENT SERVICES	PARTICIPANTS	SCHEDULE	FOCUS (not limited to)
Multifamily Group	*Parents, Youth, Proctor Parents, Skills Trainer, Therapist*	*Weekly*	*Educating and integrating treatment modules, Self regulation, Healthy Coping Cycles, Problem Solving, Resolving Trauma, Thinking Errors, and Responsible Behaviors.*
Peer Group	*Program Youth and Therapist*	*Weekly*	*Work on treatment plans as well as deal with day-to-day problems*
Community Group	*P Parents, Youth, Proctor Parents, Skills Trainer, Therapist*	*Once a month in place of Multifamily Group*	*Discuss changes in the program and engage in problem solving*
Individual Sessions	*Youth and Therapist*	*2-4 times a month*	*Youth deal with sensitive issues & work on mutuality to work through issues of Mistrust due to abuse.*
Family Sessions	*Youth, Family, Therapist*	*Once a month or as needed*	*Family members get some of their treatment needs met without the whole community looking on.*
Proctor Parent Consultation	*Proctor Parents, Therapist*	*Prior to every Multifamily Meeting*	*Supervising family of the youth will need weekly support and consultation on a variety of day-to-day behavior management and tx issues.*

PTCN's ASSESSMENT, TREATMENT & DEVELOPMENTAL PROCESS

The following Flow Chart identifies the movement of a youth through PTCN's program that integrates Neuro-developmental Stages with Best Practice Standards and PTCN's Therapeutic Proctor Care Model.



Screening and Referral

The referral packet is initially reviewed by the CEO/Clinical Director then reviewed by the PTCN team consisting of the prospective proctor parent, therapist, skills trainer, and Program Coordinator. Upon a records review the team will notify the caseworker in writing and phone about the whether or not to proceed to a screening based on reasonable fit. The team will also identify what issues would preclude the referred youth from being screened and potentially placed at PTCN.

If the team makes a determination to proceed, a panel is created to screen the youth who is being considered for program entry. This panel consists of the referring agency (DHS or DD), Probation Officer, Family/Guardian, Youth, Therapist, Skills Trainer, and Program Coordinator as well as the prospective Proctor Parents and, if possible, family members and previous placement resources.

During the screening meeting the youth, probation officer, agency and family/guardian receive PTCN's "Guide to Treatment Services" which outlines the process, principals and philosophical stance of the program. The Therapist explains the program and the assessment of treatment amenability. During the screening process a basic personal assessment is made to help ensure a good Proctor Home fit. Appropriate and available services are discussed and inquires are made to determine how well the youth will respond to a structured, stable home environment in contrast to what a residential style placement would provide.

If it is determined that the youth is not a good fit for the program, a report is prepared that articulates why the program cannot meet the youths needs at this time. For example, if the youth's physical aggression level is such that it would negatively impact the therapeutic community, PTCN would work with the caseworker to place the youth with another agency until the client can get a handle on his physical acting out. When the youth gets to the point that he no longer needs another person providing safety for himself and others, PTCN would re-review the referral packet for acceptance.

Proctor Parent Role in Youth Placement

The Proctor Parents have a ***central role*** to play in PTCN's youth placement process. Typically, a caseworker has a referral package delivered to PTCN where it is given a thorough review by the Clinical Director. The package is passed on to the clinical team for a review that takes into account the youth's needs, what PTCN has to offer that might meet those needs and then determines the best proctor home placement. The selected Proctor Parents review the referral package. They either agree to the placement or refuse the placement, citing their reasons for refusal. If they turn the placement down, the clinical team tries to alleviate the problem areas by asking DHS-CW to provide wraparound services in an effort to make the placement work for the Proctor Parents. If the services are available—the problems cleared up, the placement is made. If not, the clinical team either tries another proctor home or turns the case back.

Some youth who are referred into the program may have some prior admittance provisions to be completed, and some who are placed may have a probationary period in which the following areas will be assessed:

- Community safety – be capable of living in a community setting,
- Amenability to treatment,
- Level of risk to self and others- issues of concern excessive physical violence, person to person crime activities, fire-setting and chronic runaway issues,
- Individual fit to Proctor Parent and other youth in proctor home.

Intake

Upon acceptance to the program the attending Therapist coordinates an intake meeting, attended by referring agency (DHS or DD), Guardian, Youth, Therapist, Skills trainer as well as family members and previous placement resources. The purpose of this meeting is to complete legal documentation, develop an Initial Service Plan and agree upon roles and responsibilities of the treatment team members which ensure the service delivery fits the need of the youth and their family.

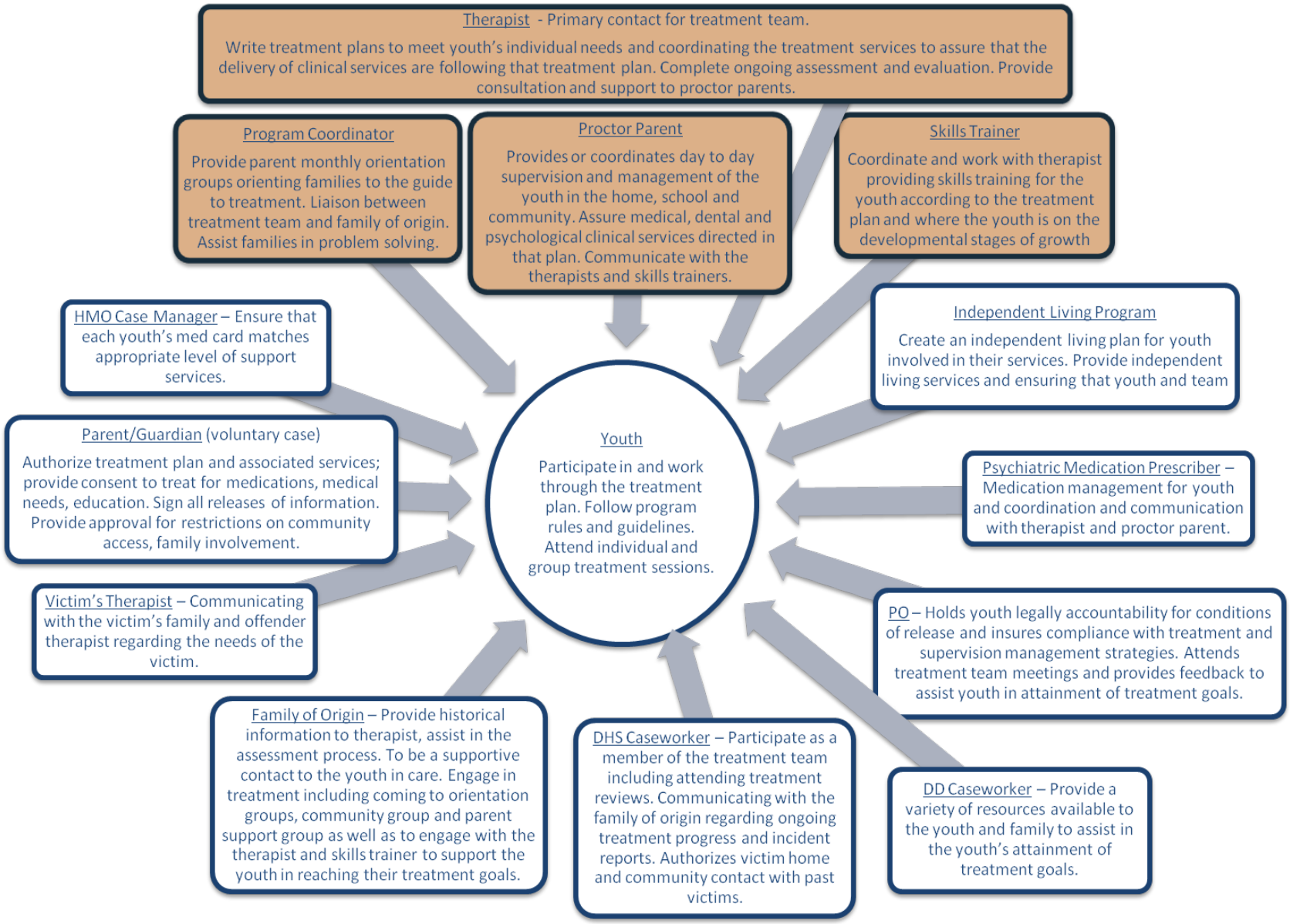
PTCN has created a ***Roles and Responsibilities Framework*** that guides the discussion and assists in each team member's function in the attainment of the goals set forth in the Initial Service Plan.

The Proctor Parents outline the house rules, their family culture and generally explain what it is like to live in their home. The youth reads aloud the treatment contract and signs it with hand-written personalization of specific individualized treatment items. At this time, all necessary legal paperwork is signed. The *parents are provided a Grievance Procedure* and walked through how PTCN communicates and desires to ***pro-actively solve problems***.

The overall treatment process is explained to every youth and his family-of-origin at the initial intake meeting. The steps and objectives of the treatment process are summarized below.

Assessment	**Stabilization**	**Working Treatment**	**Transition to Aftercare**	**Aftercare**
Objectives:	**Objectives:**	**Objectives:**	**Objectives:**	**Objectives:**
• Establish risk profile.	• Self Regulation • Establishing academic plan. • Willingness to change	• Completing Treatment Plan • Victim Clarification • Family Reunify	• Getting work. • Finding place to live on own. • Develop risk management plan. • Education	• Work after care plan • Maintain work • Support your community • Further education

If the youth's family is unable to participate in the Intake Meeting due to safety and security issues, the Therapist and the DHS caseworker together research the family structure to uncover who is a safe and healthy member who will participate, and includes the family in the most useful, practical ways available.


Therapist - Primary contact for treatment team.
Write treatment plans to meet youth's individual needs and coordinating the treatment services to assure that the delivery of clinical services are following that treatment plan. Complete ongoing assessment and evaluation. Provide consultation and support to proctor parents.
Program Coordinator
Provide parent monthly orientation groups orienting families to the guide to treatment. Liaison between treatment team and family of origin. Assist families in problem solving.
Proctor Parent
Provides or coordinates day to day supervision and management of the youth in the home, school and community. Assure medical, dental and psychological clinical services directed in that plan. Communicate with the therapists and skills trainers.
Skills Trainer
Coordinate and work with therapist providing skills training for the youth according to the treatment plan and where the youth is on the developmental stages of growth
HMO Case Manager – Ensure that each youth's med card matches appropriate level of support services.
Independent Living Program
Create an independent living plan for youth involved in their services. Provide independent living services and ensuring that youth and team
Parent/Guardian (voluntary case)
Authorize treatment plan and associated services; provide consent to treat for medications, medical needs, education. Sign all releases of information. Provide approval for restrictions on community access, family involvement.
Youth
Participate in and work through the treatment plan. Follow program rules and guidelines. Attend individual and group treatment sessions.
Psychiatric Medication Prescriber – Medication management for youth and coordination and communication with therapist and proctor parent.
Victim's Therapist – Communicating with the victim's family and offender therapist regarding the needs of the victim.
PO – Holds youth legally accountability for conditions of release and insures compliance with treatment and supervision management strategies. Attends treatment team meetings and provides feedback to assist youth in attainment of treatment goals.
Family of Origin – Provide historical information to therapist, assist in the assessment process. To be a supportive contact to the youth in care. Engage in treatment including coming to orientation groups, community group and parent support group as well as to engage with the therapist and skills trainer to support the youth in reaching their treatment goals.
DHS Caseworker – Participate as a member of the treatment team including attending treatment reviews. Communicating with the family of origin regarding ongoing treatment progress and incident reports. Authorizes victim home and community contact with past victims.
DD Caseworker – Provide a variety of resources available to the youth and family to assist in the youth's attainment of treatment goals.

Orientation/Assessment
This stage is focused on a Comprehensive Assessment, orientation to the proctor home, Integrating the youth into the PTCN community and making continuing evaluations in order to provide the most appropriate services.

The Youth
Upon entering the program each client is assigned to a proctor home and begins their introduction to PTCN's community. During Orientation, the youth is given a basic level of supervision and privileges in the proctor home and PTCN community. Later on, successful completion of a developmental phase in conjunction with adhering to their Individual Service Plan may lead to increased privileges and decreased supervision as is appropriate to their developmental functioning, age, and risk management profile.

The Family
Upon entering the program parents are provided an opportunity to attend a monthly **Parents Orientation and Treatment Readiness Group.** This allows the parents to begin a supportive dialogue about how difficult and traumatic the situation can be when learning and coping with a child who has borderline IQ and serious behavioral and emotional problems. Parents meet past program parents and current parents who can support them in the program.

Parents are interviewed by the Therapist assessing the youth for background information necessary to complete a Comprehensive Evaluation. Parents contact with their youth is being followed up on as agreed upon in the Initial Service Plan that was completed at Intake.

The Therapeutic Community
The clinical staff collaborates with the Proctor Parent during this phase to assess the youth's current level of developmental functioning. A **Psychosocial &/or Psychosexual Assessment** (completed by their attending Therapist who seeks input from the rest of the Clinical team, Proctor Parent, family and DHS or DD worker) is completed within 30 days of admission to PTCN. This report assesses trauma history, sexual, physical and emotional trauma history. The Assessment procedures are based on:

- Series of Clinical Interviews with the youth and available family members,
- Collateral Data Review,
- Behavior and Developmental Stage Tracking by Proctor Parents,
- Proctor Parent Assessment,
- Testing including but not limited to--
    - Buss-Durkey Hostility Inventory (which measures levels and types of aggressive thoughts and aggressive actions)
    - Millon Adolescent Clinical Inventory (which measures adaptive and mal-adaptive adolescent functioning)

- Trauma Symptom Checklist (which is designed to measure the youth's experiences of trauma and how they believe it affects them)
- The Marlow-Crown Social Desirability Scare (which measures how much a youth desires to fit into a community)
- Hare Psychopathy Checklist-Juvenile Version,
- ERASOR, J-SOAP, JSORRAT, (for sexual risk assessment).

The Assessment encompasses the following:

- Legal status and custody status
- Medical (including medications and dosages)
- Family (including specific Cultural factors)
- Mental Health
- Alcohol and Drugs
- Educational
- Vocational
- Social Living Skills
- Placement Planning including home visits

The following areas are addressed within each of the above mentioned domains as appropriate:

- Problems, Reason for Referral or Placement, Pertinent Historical Information;
- Child Behaviors, Response to Current Services, Strengths and Assets;
- Significant Incidents and/or Interventions;
- Supervision Level (any supervision needs greater than usual for the program);
- Identification of any service goals in that domain;
- Information from the DHS Risk/Needs Assessment.
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The clinical team works together to discover family systems history and evaluates emotional, sexual, and physical trauma. With help from the youth, family and referring agency evaluations are made on social systems, self-regulation, protective factors, educational history, sexual abuse trauma, and coping competencies. Treatment planning team members also complete a strengths/needs assessment to identify resilience, coping mechanisms, and protective factors.

Recommendations are made on treatment needs, interventions needing to be put in place and how to strengthen existing family connections. There is carefully supported family contact. The therapist contacts the family directly to gain further understanding of their history and current levels of functioning. The treatment planning team clarifies family contact including the structure of telephone, writing and face-to-face visits.

After the Treatment Team reviews the Assessment in a formal meeting, a **90 Day Master Service & Treatment Plan** is completed within 45 days of admission. The Treatment Team will meet every 90 days together to receive up-dates from PTCN and plan together any

additional strategies and supports that the youth and family will need to enhance their success in completing their Treatment Goals.

Self-Regulation – *"Stop, Look, Listen, Relax."*

This is the first and most basic level of the PTCN Neuro-Developmental system. While some youth enter at a more advanced level, many are struggling with the challenges of self regulation due to childhood trauma or developmental disabilities. Youth who have been traumatized or raised in chaotic situations/systems are more prone to having attachment issues. When co-occurring with Borderline IQ, attachment-disordered youth have difficulty bonding and creating mutuality with others. When youth have been abused and traumatized a trauma-bond is often created with an abuser. This trauma bond can be modified through learning self-regulation skill that lead to a more positive way of dealing with emotions and building healthy relationships with caretakers.

PTCN utilizes a variety of therapeutic interventions in working with youth who have attachment issues and mal-adaptive behaviors. It uses techniques like modeling, role playing, positive & corrective feedback and employs social learning principles to teach social skills in individual and group formats. These attachment challenges are met by monitoring the developmental tasks associated with self-regulation. Proctor parents play a critical role in emotional interventions like "co-regulation".

PTCN measures success at this stage by the achievement of developmental tasks such as:

- The youth's response to **co-regulation**,
- Following structure,
- How the youth attends to surroundings and activities without losing self control,
- How the youth attempts to interact positively with others,
- How easily the youth can be guided into engaging and using the social contract (as in the unspoken rules of how to interaction with others in social settings),
- Etc.

During Self-Regulation, if the family is amenable, therapy is begun. If the family has multiple abuse behaviors toward each other family visits are structured and most often held in the office. Even when held in the community they are can be supervised by the Clinical Skills Trainers as prescribed in the Master Service & Treatment Plan. The Treatment team assesses who in the family could serve as a safe and knowledgeable adult supervisor or who could become one with support and training. The clinical team creates a safety plan and community activity contract / pass contract which identify warning signs, risk situations and clarifies prevention strategies.

Remediation at the Self-Regulation level is based on the work of Stanley Greenspan, MD as further developed by Alan N. Schore,Ph.D. Schore proved that early traumatic or chaotic experiences negatively affect attachment at a neuro-endocrinological level. The remediation process is seen as a re-programming of an almond-sized and shaped brain structure section of the brain called the amygdala.

Youth with Borderline IQ limitations are generally having serious struggles in the functioning of their Prefrontal Cortex. The Prefrontal Cortex is where the Executive Function of the Brain is located. The Executive Function basically controls the ability "organize and plan" behavior. It additionally involves emotional regulation. The right hemisphere controls emotion-affect and the left hemisphere control language. Between the two hemispheres is the corpus callosum. It is a fiberous material that electrical and chemical signals must pass through to communicate with the left and right hemisphere.

In lower functioning or mentally ill youth, many who are placed at PTCN, have a co-occurring history of FAS/FAE. Emotional regulation is typically a hallmark of these two population groups and significant work is employed to begin getting the Prefrontal Cortex to work in a functional fashion.

When dealing with self-regulation, **the Therapist** is working with the youth on learning to identify thoughts and feelings and developing a framework within which they can understand and express their feelings. Therapists utilize materials from the Autism Spectrum and Developmental Disability literature to being assisting youth in developing and augmenting neuron-pathways. Getting the left and right hemisphere to communicate and calm is tedious and time consuming but rewarding work.

The other area of concentration is on the youth's honesty about their sexual offending history. The initial sexual history, taken during the intake and orientation stages, is expanded upon and the accuracy of which is assessed through the use of polygraphs.

Polygraphs are used to help the youth develop efficacy in their ability to tell the truth about the events around them and their own actions without negative repercussions. PTCN uses polygraphs as a tool with no negative consequence attached. Polygraph use is based on research in "The Value of Polygraph Testing in sex Offender Management" Pullen, English and Jones (1996) explaining that "the polygraph must be implemented within a contained approach, and multi-disciplinary collaboration with quality control efforts to yield the best solutions to sex offender management."

At PTCN, polygraphy over current sexual behaviors has been a significant factor in reducing sexual reoffense. Most youth who are placed at PTCN have an extensive sexual aggression history of abusing others in many of their previous DHS placements. Breaking this pattern of abuse and monitoring it is critical for community and home safety.

During this phase **Skills Trainers** help youth to work on reflective identification of feeling and emotional regulation states, assisting with daily creative processing and self-reflection activities. They also assist youth to appropriately respond to caregivers request on such tasks as following directions, abiding by structure, and emotionally tuning with their proctor family.

Trusting Others – *"You're Okay, I Can Share."*

According to Erik Erikson, hope is a product of trust. PTCN's treatment plan utilizes the research of Kevin Creedan M.A. LMHC ("Neurological impact of trauma and implications"), Bessel A. van der Kolk ("Traumatic Stress" published by Guilford in 2007), self-determination theorists (Deci & Ryan, 1985, 2000) and The Search Institute (Benson, Leffert, Scales & Blyth, 1998). The psychological emphasis of their work focuses on the theories of Bowlby & Winnicott (1969), stating that secure attachment provides for the development of trust and autonomy.

Here PTCN measures success by the achievement of developmental tasks such as:

- A youth's ability to share time, feelings and objects with others
- How well the youth seeks out co-regulation
- The youth's ability to calm self
- Honesty regarding daily activities and choices
- Etc.

The **Therapist** assists the youth in learning about the general cycle of mal-adaptive behaviors and gains understanding on how to work through traumatic memories. Memory work helps youth ***"learn healthy ways to reduce emotional arousal without the use of dissociation"***(Judith T. Stien & Joshua Kendall, Psychological Trauma and the Developing Brain (Haworth Maltreatment Trauma Press, 2004)). Dissociation is defined as a defensive tactic used by youth to cope with anxiety build-up in an attempt to exit an overwhelming psychological situation. Memory work is most valuable when it is found that a youth's dissociative behavior has become a neurobiological habit that prevents them from dealing with the situation at hand. This avoidance can be slowly overcome by a steady cautious effort at desensitizing youth to the problematic situations and painful memories. As the therapy progresses this memory work can unlock fears and unmask emotional triggers that hold the youth in a cycle of serious misbehaviors.

During this stage the **Skills Trainers** work with the youth on:

- Sensory-motor integration;
- Sharing with others; and
- Personal strengths and weaknesses that is an ego-strength building exercise as well as an identification process for thoughts, feelings and behaviors that cause youth to mistrust the people who are caring for them. This work is based on the cognitive distortions research of Samenaw & Yochelson ("The Criminal Personality" published by Jason Aronson in 1976), and Mottonen, D. Ed. ("What Does Your Future Hold" Valley Mental Health in 1987.

The clinical team develops plans and safety nets and puts those in place in practical ways. There are clear developments of safety plans as they youth becomes more aware of their offense cycle. Depending on safety concerns, the supervision requirements may decrease and there may an increase in social interactions in the community. There are more community based activities involving structure and recreation with family members.

During this stage, visits may be supervised by a capable, knowledgeable adult who may or may not be a member of the clinical team. The Clinical Skills Trainers work with the family, modeling appropriate interventions so that families can begin to provide safety and structure for their own youth.

Autonomy – *"I Think I Can, I Have Something of Value to Offer."*

At the Autonomy stage of development the youth's ego-strength matures and they are ready to begin establishing social trust, the ability to follow rules, accept loss and engage in their own problem solving. PTCN measures success at this stage by the achievement of these developmental tasks such as:

- Copying/imitating Proctor Parents
- Expressing wants and needs assertively
- Accepting personal responsibility
- Initiating problem solving and takes action
- Etc.

In this stage the **Therapist** is helping the youth to process trauma, by developing a personal sense of empathy. They begin working on empathy impairment and internalization of personal accountability while separating the accountability of others.

Clinical Skills Trainers assist youth with techniques like creating a victim collage & victim role play to increase victim empathy and by assisting and preparing youth to provide a detailed account of one personal offense (to diminish secrecy), restructure and clarify their misbehavior cycle. The youth is further integrated into community-based activities. As he personalizes his risk to the community and starts to understand how to cope with those risks, he is given more opportunities to practice pro-social behaviors. There are more "safe and appropriate" day-long home visits when the youth reaches this stage.

Initiative – *"I Can Do It, I Am Capable."*

The Initiative developmental stage is connected to purpose. The youth learns that they can do things on their own. He is gaining personal confidence. PTCN measures success at this stage by the achievement of developmental tasks like when the youth can:

- Identify how he tolerates frustration,
- Persevere at tasks,
- See complex cause and effect, Identifies their values as important and can express reasons why,
- Etc.

This stage finds the **Therapist** helping the youth with healthy coping strategies; integrating treatment into real life experiences, arousal management, creating a semi-independent living plan, re-structuring & identifying health vs. deviant arousal and developing a healthy system that reinforces intimacy & sharing with another person.

The **Clinical Skills Trainers** and youth work together on independent living skills, employment opportunities and healthy coping strategies specific to the youth's personal

struggles. The Clinical Skills Trainer also helps the youth to recognize the specifics of their personal offense cycle and fine tunes their cognitive re-structuring.

At this stage, Youth are being held more accountable for functioning in the school and community. They are often permitted as much unsupervised contact in the community as risk management strategies allow. The clinical team and referring agency discuss extended family visits.

Industry – *"I can succeed, I can learn, being productive is meaningful."*
In this stage, the youth begins to develop a sense of self worth in relation to others and can recognize major disparities in personal abilities relative to other youth. They also grasp an understanding of personal competence. The Youth are able to produce and give back to their community and feel they fill a valuable role in their family and community. They are a productive member of the treatment team. PTCN measures success at this stage by the achievement of developmental tasks such as:

- Tracking the youth's enjoyment of learning
- Taking pride in their accomplishments
- Demonstration of empathy, demonstrating of group loyalty
- Maintaining group values
- Etc.

The **Therapist** continues working with the youth to enhance and mature adaptive coping strategies and social development.

The **Clinical Skills Trainer** assists the youth with re-assessing their strengths and weaknesses, as the youth is now more capable of giving a more accurate representation. They encourage peer-to-peer relationships both inside and outside of the treatment community, and they support the growth of ego-strength to work through family-of-origin issues.

Youth who have reached this developmental stage are ready to begin to deal with healthy separation from caregivers with appropriate adolescent independence and are more capable of establishing healthy cross gender relationships. Youth may receive unsupervised community access, unsupervised peer-to-peer interactions and increased choice in their proctor home environment. Family is encouraged to engage their Youth in life skill activities to assist with their preparation for a return to the general community in an independent living, semi-independent living or family situation.

Group Identity – "*I am not perfect, you're not perfect but I can accept that."*
Youth begin to question themselves, how they fit in the community and direction of their lives. Youth value loyalty and fidelity to the group and seek out positive influences and community contacts. PTCN measures success at this stage by the achievement of developmental tasks such as:

- Youth keeps commitments
- Thinking fades from black & white. Youth prefers shades of grey
- Is more open minded

- Bases values on societies laws
- Etc.

In this stage, **Therapists** work with the youth on their leadership within their peer group, clarifying their role as a mentor and sharing their stories in socially appropriate ways within the peer group.

The **Clinical Skills Trainers** help the youth on relating their personal growth through treatment to others, confirmation of an after care plan for successful independent or semi-independent life and setting this plan into motion. The clinical staff encourages family visits aimed at re-integration into the family and community following treatment as is safe and appropriate.

Individual Identity – *"I can regulate my behavior, select and guide my decisions and actions, without undue control from or dependence on parents"*

Erikson describes the Individual Identity stage as autonomy from caretakers where youth develops a defined sense of self and becomes secure in their ability to successfully integrate into their community. PTCN measures success at this stage by the achievement of developmental tasks such as:

- Positive risk taking
- Open-mindedness which matures while maintaining integrity
- Integrates values and laws into their personal beliefs
- Gains personal meaning in spiritual expression
- Etc.

The **Therapist** helps youth on planning aftercare resources, developing and instituting local support systems within the community where the youth will return. The Therapist helps Youth to develop personal means of monitoring their own functioning and self-reflective techniques to ensure healthy coping.

The **Clinical Skills Trainers** work with the youth to implement the transition, coordinate with local natural supports to ensure continuance of after care plan and network with community resources to assist with successful independent or semi-independent living. The clinical team partners with the youth to develop a celebration and recognition ceremony.

Developmental Stages Summary

The multi-stage developmental process at PTCN has been presented in a linear fashion for clarity. Working with the population for this RFP is rarely so simple. The challenges are many and learning the integration of positive behaviors can be difficult. Often youth show regression in their development tasks and sometimes even in their development phases. PTCN provides a community environment where Youth can learn, fail and be given an opportunity to try again.

Moving on to the Next Level

Working in a true Multi-systemic therapeutic community requires the help of many people. When a youth feels that they have finished their work in any one stage—by consistently scoring in the 75th percentile achievement on the developmental tasks associated with this stage (see Measuring and Tracking below) they can petition the therapeutic community to move to the next level of developmental functioning.

Length of Program

PTCN conducts a long term program because low-cognitive functioning youth are most often challenged by factors beyond their maladaptive behavior. Youth with borderline intelligence or their mental illness are often not able to just take in information in a didactic format. PTCN is also prepared to deal with those who present multiple DSM-IV diagnoses which often coexist in this population of youth. Challenges like these may keep a youth in the program for 5 years, even more in some cases. Progress can be slow and the program utilizes multiple interventions which are most effective over time. The program is designed to fill all of a youth's individual needs, including the time required for treatment of all the interwoven issues. ***Possible aftercare situations are assessed and proposed within 30 days following intake and then updated as changes occur.*** Treatment goals are based on the possible aftercare situations and what would need to occur in order to make that situation a safe one for the youth and the community.

In the case of a return-to-family, the program provides family therapy, skills building and

PTCN believes that a community based program allows youth to practice skills that maximizes their Functional Abilities and improves their success for semi-independent living. PTCN empowers the youth's family by training them in supported living strategies.

outlines the steps for returning to the permanent family living situation. If the youth will be moving out on his own after the program, PTCN first works with ILPs (Independent Living Programs) to create a Semi-Independent Living Plan. The tasks in this plan are ***designed to build skills for independent activities and provide for a smooth transition while taking into account appropriate developmental level, ability and assessed risk.*** PTCN has the resources for Youth live in a Proctor home until he is ready to live on his own, if necessary due to issues such as a lack appropriate family resources.

Discharging from PTCN

When the operationally defined outcome goals of the treatment plan have been met, stepping down into a less restrictive placement or modifying the current placement in an after-care setting is appropriate. The step-down process is a coordinated effort between the youth, family, clinical staff and caseworker. Together they determine types of services that will help the youth maintain the developmental, behavioral and psychological changes that were brought about through the intervention. Therapists provide a written discharge summary report with within fifteen days of completion of services. The report includes

information regarding who participated in the intervention, specific treatment approaches, skill-based interventions that the youth completed, outcome of treatment and a follow-up plan developed with the family and the caseworker. The final tasks in PTCN's discharge process is the completion of three follow up contacts within the first quarter after transitioning out of the program. Every effort is made to go beyond the minimum and make all three contacts face-to-face meetings.

Rules & Expectations

- No contact with past victims (no matter what the reason)!
- All visits with family must be pre-approved **one week in advance** or they will need to be rescheduled. Pre-approval comes from the therapist, proctor parent, and multifamily group.
- Treatment comes first, school and other activities (driver's license, work, recreational activities) may have to be sacrificed for a while in order to earn the appropriate level to participate.
- Passes and visits cannot occur at the proctor home.
- All passes are initially supervised by the Skills Trainer and debriefed at the end. The Skills Trainer then debriefs with the therapist and reviews with the family. Parents begin supervising once they've demonstrated community safety skills, the youth is following their directions, and they are working together on their treatment issues constructively.
- Family members who become hostile or violate their Parent/Guardian contract may be suspended from participation until the issue is resolved and a constructive plan is enacted.
- Generally, the family cannot visit the foster/proctor parent home and the home's address and phone number is restricted until a professional working relationship is established. Each foster/proctor home may have personal rules for this also.
- The youth may only have visitation and passes with family members that directly participate in Multifamily Groups of those who have filled out the Knowledgeable Adult Supervision Form.
- Clarification with past victims will not occur until the youth has passed a polygraph on his/her offenses. Clarification will occur in small graduated steps and only at the victim's pace. (See Standards of Care for Clarification)

- All newly disclosed sex crimes shared in treatment are reported to your case-worker or probation officer or the necessary agencies.

- Failing or Inconclusive results on your Maintenance Polygraph can result in Developmental Stage drops.

Standards of Care for Clarification

Victim safety is a primary concern during your treatment process. Therefore the following standards will be our guidelines prior to face-to-face clarification with your past victims. Over 75% of the youthful offenders at our program have victims living with their parents and are unable to return home. Some of the youthful offenders will be able to reunite with their families and live back at home with the victim. The return home, is a long process and can take 6 months to a year after clarification has begun.

Reunifying the family at the expense of the victim will not be practiced here. The victim will need to be in his/her own therapy prior-during-after the clarification process and through family reunification. In order to ensure that the victim's needs are being accurately addressed the victim's therapist needs to be approved by our program. The victim's therapist must be willing to work with us and have sufficient knowledge of sexual trauma and offender psychology.

Prior to reunification, Clarification with the victim(s) will be completed. The following are minimum standards and subject to change due to growths in the professional community/research and victim safety.

Prior to face-to-face contact the offender must:

- Take 100% responsibility for the offending and his/her deviant sexual behaviors;
- No Treatment Contract violations and complete program compliance;
- Proven 100% honesty in reporting of deviant sexual behavior--validated by polygraph;
- Passing maintenance polygraphs;
- Controlling deviant sexual arousal;
- On level III and working Treatment Plan within time frames provided;
- Completing all treatment work satisfactorily;
- Completed clarification with parents-caretakers;

The parents must:

- Demonstrate awareness that the offender has a life-long propensity towards sexual deviancy;

- Demonstrate working knowledge of the offender's grooming behaviors and stages in cycle;
- Demonstrate ability to hold offender accountable for all actions;
- Demonstrate ability to assist the offender in breaking his/her cycle;
- Accept responsibility for their predisposing family/parenting behaviors to deviant sexual acts;
- Understand how their marital conflict impacts offender's risk for reoffending and victim's risk for not disclosing abuse effects and sexual abuse behaviors;
- Supports Treatment Program and level system;
- Takes active role in Multifamily Group;
- Demonstrates adequate understanding of victim impact and concretely understands the needs of the victim(s).

At this time we have identified **6 basic stages** in the clarification process:

1. **Evaluation of victim, offender, parents, and family readiness.**
2. **Preparation of clarification letter.**
3. **Letter provided to victim.**
4. **Clarification questions.**
5. **Preparation for clarification meetings.**
6. **Clarification meetings.**

Clarification does not entitle the offender to move back home, it is the beginning of the possibility of visitation and reunification.

Standards of Care for Visitation & Reunification

Reunification with the family and victim is a long process to ensure safety for the victim. At this time we see 5 phases to guide the reunification process. During and after each stage, all members on the treatment team, evaluate and assess that prescribed standards are completed before moving to the next phase. The 5 phases are:

Phase I: Individual, group, intact family (all members but the offender) and marital therapy for the victims, parents, siblings, and offender which lead to family sessions with the offender.

Phase II: Visitation with the offender outside the home and clinic setting.

Phase III: Visitation in the home.

Phase IV: Overnight visitation in the home.

Phase V: Completion of the family reunification process.

The following is minimum criteria that must be completed in the first phase of reunification:

- Parents are involved in multifamily group;
- Victim is in therapy;
- Parent to victim relationship and sibling relationship issues like anger, betrayal, blame, and trust have been satisfactorily addressed;
- Parents are demonstrating consistent emotional support to the victim(s);
- Parents do not deny, minimize, or rationalize the offender's behaviors;
- Parents have working knowledge of offender's grooming tactics;
- Family has demonstrated competence in assertiveness skills;
- Family is using positive problem-solving techniques;
- Behavior management training for the parents in discipline and supervision of the offender;
- Parents and siblings do not minimize the offender's actions.

For the victim sibling(s), the following needs to be completed in Phase I according their developmental needs and abilities:

- Able to talk and process the abuse and how it has impacted him/her;
- Identify and discuss feelings of the abuse and its impact;
- Place full responsibility on the offender;
- Maintain positive relationships with his/her parents;
- Show age appropriate assertive behaviors with all family members;
- Have confidence in parent(s) ability to act as a protective parent;
- Clarification must be completed where to offender takes full responsibility for the abuse.

There are additional criteria in the other four Phases that will be provided to the youthful offender and family when the clarification and reunification process is begun. Reunification is a complex process and takes time. Attempts to rush or force the process will only delay progress.

The treatment process is slow and confusing at times, **please ask questions and clarify anything you may see and hear.** It is not always possible to define all things specifically; so additional rules and conditions will be always considered. The standard protocol for exceptions to the rules is talk to the (1) Program Director, who may decide at the time of the request and/or (2) will defer to the Multifamily Group for discussion and a vote.

Once again, Welcome to Professional Therapeutic Community Network, PC!
STAT, PC 1996 Original. Updated June 2008. (*The preceding Standards of Care for Clarification/ Visitation/Reunification were adopted from Center for Behavioral*

***Intervention & Mary Meinig, MSW Violence Update: Returning the Treated Sex Offender to the Family, Oct. 1990.*)**

(This is a working document which will change over time based on knowledge learned and current trends in research.)

Jesse L. Watson, MA
CEO

ADDITIONAL INFORMATION

EVIDENCE BASED PRACTICES

Evidenced based practices enhance the services PTCN provides to its youth, their families, community partners, schools, and to increase communication about the interventions it provides.

For the past 4 years, the professional mental health field has begun exploring Evidenced Based Practice that has emerged from Best Practice Standards. PTCN adopts the following definition of what Evidenced Based Practice involves as defined by the American Psychological Association:

"Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences."

"Evidence-based practice requires that psychologists recognize the strengths and limitation of evidence obtained from different types of research. Research has shown that the treatment method (Nathan & Gorman, 2002), the individual psychologist (Wampold, 2001), the treatment relationship (Norcross, 2002), and the patient (Bohart & Tallman, 1999) are all vital contributors to the success of psychological practice. Comprehensive evidence-based practice will consider all of these determinants and their optimal combinations. Psychological practice is a complex relational and technical enterprise that requires clinical and research attention to multiple, interacting sources of treatment effectiveness. There remain many disorders, problem constellations and clinical judgment and knowledge of the best available research evidence to develop coherent treatment strategies."
Evidenced Based National Task Force Report, American Psychological Association, July 2005.

TREATMENT PHILOSOPHY

PTCN's ***Neuro-Developmental Model*** is informed by the latest research on Post-Traumatic Stress and how it impacts brain development. Over the last 10 years, 100% of the youth served in PTCN's BRS placements have co-occurring PTSD and cognitive impairments related to environmental insults (abuse, neglect, fetal drug effects, head trauma, attachment disruptions, etc….). Research in the last 5 years has provided additional knowledge about how trauma impacts brain development and the resulting behavioral disorders in social-emotional functioning.

Abuse and Neglect remain the most common cause of chronic traumatic stress in children. Yet, repeated losses, separations, and exposure to family violence has a similar impact. In Bessel van der Kolk's (Trauma, Memory, and Self-regulation, 1997) work he found that boys who witness violence by their fathers have a 1000 percent greater likelihood of

growing up to abuse their partner than men who were not exposed to marital violence when they were young.

A growing body of research is emerging to indicate that for abused children the earlier trauma occurs, the longer it lasts, and the more intense it is determines the severity and malignancy of its effects. Additionally, the prognosis is worse when the abuse is at the hands of a parent rather than a stranger. Therefore, because of the deep neurobiological wounds associated with prolonged abuse, recovery for these children is a far more difficult and arduous process.

Brain Impairments due to Trauma

Each youth with a traumatic history and lower intellectual functioning comes with their own particular set of symptoms in response to trauma. Many youth have the same types of trauma but do not necessarily manifest the same disorder. They do share similar developmental disturbances and a range of symptoms associated with stress-induced neuro-deficits. There appears to be four domains of neurological impairment:

A. ***Dysregulation of the Stress Response System and Limbic Irritability.*** What occurs in this area is serious impact on the child's amygdala. Repeated traumatic stress creates a highly reactive response to stress there by the child requiring very little to set him/her off in an emotionally dys-regulated state. Overwhelming stress appears to alter neurotransmitters and hormones involved in the stress response system. It alters brain structure that provides an inhibitory stress function. Chronic maltreatment can lead to opposite functions that PTCN sees in many of the youth it serves. When a normal youth is under stress his/her nervous system is activated and goes into a hyperaroused state. Chronically abuse youth get the reverse effect and exhibit a state of apparent calm. This activation essentially decreases epinephrine, norepinephrine, etc.. which normally are increased. This state of reverse calm under stress induces a soothing numbness to their body. It has been described as "it is like riding the gas and the brake at the same time" while simulateously resulting in a "freeze response". (Allan Schore, *Effects of early relational trauma on right brain development, affect regulation, and infant mental health*. Infant Mental Healthy Journal, 22, 2001). Over time this becomes a primitive defense mechanism to dissociate from bodily sensations and current reality may become a child's primary adaptation to stress (B.D. Perry. *Violence and Childhood*, 2000).

B. ***Decrease in the Hippocampal Volume & Abnormal Activity in the Cerebellar Vermis.*** The hippocampus is the hub of conscious memory and learning. The hippocampus brings together memory traces and replays them over and over where it is integrating the experience and etching it further into longer term memory. Eventually memories are linked together independently of the hippocampus. Until memory is etched into long term memory the hippocampus has to retrieve and process. Abuse and neglect damage the hippocampus in reducing its size

and circuitry. This impairs verbal memory. Trauma triggers significant amount of cortisol to protect the body. Too much cortisol eats at the neural network of the brain. This damages the hippocampus and in abused children impairs their ability to process current experiences. A breakdown in emotional regulation and integration of memory adds to the fragmentation and learning problems.

C. ***Underdevelopment of the Left Hemisphere & Communication Problems between Brain Hemispheres.*** Maltreatment appears to impede normal development of the left side of children's brains (Teicher, et al., 1997 & 1998. The left side of the brain was less developed than the right side in abused children. They were also abnormalities in the corpus callosum (fiber tract that connect the left and right sides) and abused children struggled with laterality problems (ability to tell left from right and impaired motor skills). Brain size in abuse children was also assess and found to be smaller than non-abused children. The longer a child was abuse the smaller their brain and the more symptoms of intrusive thoughts, avoidance, hyperarousal and/or dissociation.

Decrease in IQ was correlated with smaller brain size. Underdeveloped left side of the brain tends to impede development of language and reasoning skills. Meta-cognition (thinking about your own thinking and monitoring ones self) and self regulation of negative emotions were impacted. If the left and ride side of the brain are not in sync, higher order thought and emotional processing are impaired (Hoptman & Davidson, 1994). This can add to memory fragmentation and emotionally states can be so over-whelming because access to language to process is inhibited.

D. ***Neuroendocrine & Immune System Dysfunction.*** Abuse & neglect appear to also influence growth-related hormones. Wang, Bartolome,and Schanber, 1996 at Duke University discovered that a biological chain of events that link touch to the suppression of growth. Van der Kolk is finding that there may be a direct link between adverse childhood experiences and a greater likelihood of adult diseases such as cancer, lung disease, diabetes, and heart disease.

A Psycho-biological Model is emerging that described the results of repeated trauma on brain development and function. The research is indicating that nearly all the psychological symptoms brought by trauma have an associated neurological impairment. There appear to be 7 core symptoms:

1. **<u>Problems in regulating emotional & arousal:</u>** Abused children and limited intellectual functioning youth tend to oscillate between extreme arousal or numbed responsiveness. They have no feelings or too many to process. Chronically traumatized children tend to engage in self destructive behaviors to regulate emotional states. Borderline IQ & Pervasive Developmental Disability youth often times have a ***Non-Verbal***

Learning Disability. They are considerably less proficient in identifying facial expressions of emotion (McAlpine, C. and Kendall, KA. *Recognition of facial expression of emotion by persons with mental retardation*, American Journal of Mental Retardation. 1991). Failure to recognize emotion accurately in others leads to serious misinterpretations of others intent and a projection of trauma related fears onto others.

2. **Alterations in consciousness and memory:** Dissociation is oftentimes seen in youth with traumatic experiences. It can become a way of life. It provides the abused child with a means of avoiding painful memories and the terror of on-going abuse. When abuse is chronic, children are more likely to experience amnesia, especially if they continue to live with the perpetrating parent (Chu, et al. *Memories of Childhood Abuse*, 1999). Dissociation blocks the full perception and storage of the memory is incomplete. Unfortunately not only does the youth begin to forget their own trauma but a distorted sense of reality with the family and others emerges. Abused youth have so much to feel but struggle processing it.

3. **Damage to self concept and identity:** A youth's identity or self concept is rooted in how others treat them. Typically abused youth see themselves as weak, ineffectual, helpless, and utterly alone. They mistakenly assume they deserved the abuse. Sometimes in an attempt to preserve their attachment to the parent they will fragment the abuse and/or rationalize it.

4. **Disruptions in cognitive capacities:** A growing number of studies are finding that abused children had significantly lower IQ scores. Verbal IQ was the lowest (Carrey, NJ. *Physiological and cognitive correlates of child abuse.* Journal of the American Academy of Child and Adolescent Psychiatry, 34. 1995) Trauma tends to create a rigid thinking style and is compounded by limit IQ status. This impacts a youth ability to cognitively adapt to change and associating appropriate rules to the emerging situation. A youth's play is also constricted and affects how they learn about their world, themselves, and problem solving.

5. **Hyperactivity and attention problems:** Abused children tend to have attention problems due to being emotionally dys-regulated. They are constantly scanning the environment looking for clues to suggest something bad may happen.

6. **Relationship problems:** There are intimacy deficits in the lives of abused children given that their lives have been full of attachment losses and multiple disruptions in placements. Some may long for emotional connections and fear it while other are repulsed by it and avoid mutuality with caretakers at all costs. Mutuality is a difficult and suspect process for abused children.

7. **Alteration in the systems of belief:** Repeated trauma shatters a youth's system of beliefs. Belief systems are the way they view they view themselves, the world, and their place in it. Cognitive distortions are means of processing painful experiences and avoiding shame or responsibility for their own actions when they begin to harm others.

PTCN has found that the earlier remediation interventions are used in working with trauma affected borderline IQ youth the greater the treatment effect is in resolving PTSD symptoms and developmental impasses.

Daniel Seigel, a leading authority in attachment and neurology reports:

A major theme of attachment research and effective treatment studies is that intervention via the medium of the attachment relationship is the most productive approach to creating lasting and meaningful results. Attachment research suggests a direction for how relationships can foster healthy brain function and growth: through contingent, collaborative communication that involves sensitivity to signals, reflection on the importance of mental states, and the nonverbal attunement of states of mind.

The quality of attachment youth have with their caregivers is related to their ability to self regulate. ***PTCN's Neuro-Developmental Stages*** provide detailed assessment information about what needs to be worked on in order for the youth to resolve trauma influenced developmental impasses.

Borderline Intellectual Functioning

In the past twenty years, professionals in mental retardation and developmental disabilities have become increasingly aware of the importance of mental health issues and psychiatric disorders in working with people with intellectual disabilities. There has been growth and development of the National Association for the Dually Diagnosed (NADD), recognition of the mental health issues of persons with mental retardation in major diagnostic manuals (DSM-IV, AAMR diagnosis and classification), and the establishment of professional outlets devoted to dual diagnosis (NADD Bulletin, Mental Health Aspects of Developmental Disabilities). Additionally, there has been a significant increase in research and scholarly contributions on dual diagnosis in both journals focusing on mental retardation/developmental disabilities/intellectual disabilities and in more general journals in psychiatry/psychology and related areas.

The research, however, has focused primarily on adults. For example, in two primary professional outlets that focus on dual diagnosis, The NADD Bulletin and Mental Health Aspects of Developmental Disabilities, the vast majority of articles focus on adult or general dual diagnosis issues. An informal review indicates that less than 10% of the articles have specific or major themes on child and adolescent issues. The Journal of Clinical Child and Adolescent Psychology had no articles with a major focus on issues of children and adolescents with mental retardation. The Journal of the American Academy of Child and Adolescent Psychiatry fared somewhat better, relatively, consistently publishing a number of articles about children or adolescents with mental retardation. However, the focus of these articles is relatively narrow, largely presenting studies on medication effectiveness or atypical case studies. Overall, it is apparent that mental health issues of children and adolescents with intellectual disabilities has garnered little attention in the professional and research literature.

Treatment and prevention interventions in childhood and adolescence may partially ameliorate more severe issues in adulthood. The mental health needs of children and adolescents with mental retardation appear to parallel patterns seen with adult populations. Further, there are options for both assessment and therapeutic interventions with children and adolescents that appear to be underutilized. Additionally, comprehensive services in the community appear to represent a "missed opportunity" for both assessment and intervention.

PTCN believes that effective therapeutic interventions can also be carried out in a variety of settings. A small meta-analysis was also consistent with the moderate levels of overall effectiveness. A closer analysis of the child/adolescent findings shows outcome and effectiveness rating were generally comparable to those studies conducted primarily with adults. Twenty-four (26% or the 92) studies were conducted with children or adolescents. Of those twenty-four studies, 42% were conducted with children or adolescents identified as being in the mild range of mental retardation, with 58% identified as being in the moderate or lower range of mental retardation. Individual and group interventions were equally represented, and there was a range of the theoretical bases for the interventions. In general, the child/adolescent research base did not look substantially different from the adult base. Prout and Nowk-Drabik noted that the overall finding of moderate levels of effectiveness and benefit suggested that psychotherapeutic interventions should be more frequently considered in treatment plans with person with mental retardation.

Another promising study evaluated Multi-dimensional Therapeutic Foster Care (MTFC) compared with group care (GC) for chronic child/adolescent behavior problems (Chamberlain & Reid, 1998). MTFC integrates multiple intervention modes, including individual and family therapy, and social skills training, in multiple domains such as family, school, and peer group. The parents were trained in the use of behavior management techniques (see Chamberlain & Reid, 1998). The MTFC intervention produced more favorable results, with boys showing improvement in academics and a decrease in legal interventions. They had fewer behavior problems, fewer delinquent acts, including serious or violent crime. The authors state firmly that the lynchpins in the program (which has been conducted over 15 years) are the foster (proctor) parents, who are carefully selected, trained and supported.

PTCN has been assessing and treating youth for over 10 years who exhibit interpersonal aggression, cruelty to animals, property destruction, fire setting, sexual acting out to and with others, impulsive, tantrums, argumentative, defiant, and running away. The majority of youth also have cognitive and emotional difficulties that include one or more of the following: depressed or withdrawn, drug affected, organic impairments, inability to understand cause and effect, cognitive processing problems, inability to recognize danger, impaired reasoning skills, low frustration tolerance, deficits in interpersonal skills, and have a history of multiple failed placements and abuse and neglect.

PTCN is able to utilize the emerging Trauma informed Neurological research into practical daily interventions in assisting their youth in over-coming developmental challenges. PTCN has integrated the central construct that research demonstrates:

"Building solid attachments with caregivers is the foundation for improved self regulation and resolving developmental trauma."

RESEARCH INFORMED INTERVENTIONS AT PTCN:

PTCN uses research informed assessment and treatment interventions. PTCN has been engaged in Best Practice Standards from its inception. Two of its principal clinicians have been developing Best Practice Standards for over 20 years—they have written policy for National Task Forces and consulted with DHS-CW, OYA, and SPD in the development of Best Practice Standards.

The Best Practice types of services employed at PTCN involve ***a Multi-modal*** approach to ensure a comprehensive integration of interventions. These include the following:

1. Individual Counseling
2. Group Counseling
3. Multi-family Group Counseling
4. Individual and Group Skills Training
5. Family Counseling
6. Developmental Stage and Level System Tracking
7. Community Supervision

PTCN provides individualize treatment planning and interventions for the youth it serves. The following intervention types are research informed in working with Borderline IQ, Autism Spectrum Disorders, Complex PTSD, Attachment Disordered, and Developmental Disorders.

1. **Cognitive-Behavioral Therapy**. There is robust research on cognitive restructuring and altering cognitive distortions in most behavioral disorders. This applies to juveniles who alter their mental framework to rationalize and justify serious misbehaviors. A small but reasonably rigorous body of literature addresses treatment effectiveness sufficient to shape treatment approaches.
    a. Williams & Jones, 1997 – found internalized control over behavior with MR/DD clients.
    b. Arrowclough et al., 2001; Kuipers et al., 1997; Oosterban, van Balkom, van Oppen & van Dyke, 2001 – benefits maintain and increase over time.
    c. Tafrate, 1995; Edmondson and Conger, 1996; Beck and Fernandez, 1998 – CBT treatment of anger and aggression is effective for adolescents and adults.
    d. Murphy & Clare, 1991; Black and Navaco, 1993; Howells, Rogers, & Wilcock, 2000 – reported case histories of people with aggressive behavior had reduction in aggression levels with group and individual CBT.

e. Moore, Adams, Elsworth & Lewis, 1997; King, Lancaster, Wynne, Nettleton & Davis, 1999 – clinically significant post treatment reduction in aggression for DD clients living in the community.

2. **Social Stories.** Originally created by Carol Gray, MS to work with Autism Spectrum Disorders. These stories work equally well with borderline IQ youth in developing new skills and working through traumatic memories. Low cognitive functioning youth have little sense of what is called the "Social Contract" (unspoken social mores and rules).
3. **Comic Strip Conversations.** Carol Gray, MS created these to address social interaction and sequencing. PTCN tailors these to teach and assist their low-functioning youth in the development of new skills and processing difficult trauma related issues.
4. **Role Playing**. Used in victim empathy enhancement and developing new skills acquisition in self-regulation, assertiveness, anger management, etc. (*Daniels, Maxin. "Use of Role Play to Develop Empathy and Relapse Prevention", 2005*)
5. **Skills Building**. Training employed to develop and practice new skills and make treatment work in the real world that is supported and coached. *(Steele, Elkin, Roberts. "Handbook of Evidence-Based Approaches to Social Skills Training with Children and Adolescents", 2007*). Social skills focus on (but not limited to):
   a. Self soothing & calming;
   b. Creating positive interactions;
   c. Getting to know others;
   d. Starting Conversations;
   e. Making Requests;
   f. Recognizing and expressing feelings directly;
   g. Setting personal limits and boundaries;
   h. Putting self in others shoes;
   i. Problem solving; etc…..
6. **Multi-systemic-modal treatment Interventions**. (*Bourduin & Schaffer, 2002*). PTCN pulls from this holistic model in which the youth's family, school, work, peer's and neighborhood are viewed as interconnected systems with dynamic and reciprocal influences on the behavior of family members. This framework supports PTCN's Therapeutic Community model. Researchers also note the promise of Multisystemic Therapy (MST) with low cognitive functioning youth who have serious mal-adaptive behaviors. They sight the sound research design and positive outcomes from treatment efficacy studies (*Borduin, Henggeler, Blaske, & Stein, 1990; Borduin & Schaeffer, 2002; Saldana, et al., 2006*). Those that received MST evidenced fewer behavior problems, improved family and peer relationships, better academic performance, and reduced rates of recidivism.
   a. Bourdin, 1999 – used with success with violent and chronic adolescent offenders.
   b. Chamberlain & Reid, 1998 – produced favorable results with adolescent males (15 year follow-up).

7. **Art Therapy.** PTCN utilizes art therapy based interventions in helping youth resolve abuse and neglect trauma; work on issues indirectly where direct focus would increase over-whelming negative emotions; explore roles and social norms; discover and discuss family dynamics; and develop a Trusting Relationship with caregivers. (Riley, Shirley. Integrative Approaches to Family Art Therapy. 1994).
    a. Tomasulo, 1998 – Interactive Behavior Therapy uses role playing with MR/DD clients to develop concept integration.
8. **Motivational Interviewing.** This is a person-centered, directive method of communication for enhancing intrinsic motivation to change by exploring and resolving ambivalence. *(Prescott, D. Evidenced Based Practices, OATSA. 2007*) PTCN staff use Motivational Interviewing techniques in working on youth's trauma, mal-adaptive behaviors, family conflicts, and working through emotional impasses. PTCN clinical staff and proctor parents are trained in the six stages of change: Precontemplation; Contemplation; Preparation; Action; Maintenance; and Relapse.
9. **New Me/Old Me.** This approach was developed by James Haaven, MS for working with MR/DD individuals to assist them in differentiating harmful behaviors that had become ingrained in their self image. This approach allows for a thoughtful differentiation of harmful behaviors and integrating of newly acquired healthy behaviors to build a positive self image.
    a. Blasingame, et al., 2006 – identifies "old me" cognitions leading to problem behaviors.
    b. Brown & Pond, 1999 – associate body sensations with feelings & feelings come and go in waves.
    c. Linehan, Dialectical Behavior Therapy, 1993 – help identify and label feelings.
10. **Trauma Remediation and Rebuilding Attachments**. This ***trauma informed*** work assists in understanding the physiological and neuro-developmental responses to stress, developing strategies for improved self regulation, attachment to caregivers, and improving executive brain functioning. *(Creeden, Kevin. "Trauma, Attachment, and Neurodevelopment,2005).*
11. **Sensory Motor Integration.** Frank Belgau, 2001, created the **Learning Breakthrough Program** a sensory motor integration program that all PTCN staff and proctor parents have been trained in. Research has shown that it is important to have interventions engage more areas of the brain which means that treatment must be multi-modal and engage the sensory-motor areas of the brain in which language is compromised.

PTCN's Therapists are members of the Association for the Treatment of Sexual Abusers which defines Ethical Standards and Assessment and Treatment requirements for working with sexual aggression.

At PTCN Best Practice Standards in working with juvenile sex offenders in based on three complementary intervention elements:

1. **The need to maintain public safety**. Special precautions must be taken to ensure that past and potential victim's safety is secured. Neither the physical safety and psychological security of previously victimized children should be compromised by the youth's presence in the community nor should offending youth have ready access to individuals who may become potential victims. In support of this goal PTCN has carefully crafted Risk Reduction Strategies that account for
    - Static and Dynamic Risks Factors for reoffending
    - Necessary levels of supervision in specific areas of home and community functioning
    - Risk Management Plan for school
    - Comprehensive educational training for all adults engaged in supervising and managing youth at PTCN.
2. **The need to hold offenders accountable for their offending and responsible for their future actions.** Having youth be accountable what they have done and take responsibility for altering their mal-adaptive behaviors is imperative in preventing further reoffending. To this end, PTCN engages it youth in therapy, community service, and victim restitution projects designed to enhance their awareness of harm to others and their families. Making amends for harmful behavior is important in becoming law-abiding, productive members of society.
3. **The need to present offending youth with opportunity to receive specialize treatment designed to reduce their risk of re-offending.** PTCN provides specialized treatment that covers the following domains.
    a. Healthy Sexuality and Appropriate Social-Sexual Behaviors
    b. Restructuring Cognitive Distortions
    c. Mapping out their Sexual Offense Pattern
    d. Developing Healthy Coping Patterns
    e. Victim Traumatic Impact
    f. Victim Clarification
    g. Disclosing Sexual History and Breaking Patterns of Secrecy
    h. Reoffense Prevention
    i. Sexual Arousal Management and Deviancy Restructuring.

The Treatment areas are fully addressed in a 90 Day Treatment Plan. The Best Practice interventions employed at PTCN to work on these areas involve the following:

Individual Counseling
Group Counseling
Multi-family Group Counseling
Individual and Group Skills Training
Family Counseling
Developmental Stage and Level System Tracking
Polygraphy
Arousal Restructuring and Management

To date in the juvenile sex offender field there is no comprehensive program that meets the criteria of what it means to be Evidenced Based. What does exist is research on what components are involved in the assessment and treatment of juvenile sex offenders and how effective they may be. PTCN uses research informed assessment and treatment interventions as noted in our previous definition of Evidenced Based Practice by the APA.

Research Informed Interventions at PTCN (but not limited to):

Cognitive-Behavioral Therapy. There is robust research on cognitive restructuring and altering cognitive distortions in most behavioral disorders. This applies to juvenile offenders who alter their mental framework to rationalize and justify sexually abusing others. (*Alexander, M.A. Sex Offender Treatment Efficacy, 1999*)

Role Playing. Used in victim empathy enhancement and developing new skills acquisition in self-regulation, assertiveness, anger management, etc. (*Daniels, Maxin. "Use of Role Play to Develop Victim Empathy and Relapse Prevention", 2005*).

Skills Building. Training employed to develop and practice new skills and make treatment work in the real world that is supported and coached. *(Steele, Elkin, Roberts. "Handbook of Evidence-Based Approaches to Social Skills Training with Children and Adolescents", 2007*).

Multi-systemic therapy. (*Bourduin & Schaffer, 2002*). PTCN utilizes the holistic model in which the youth's family, school, work, peer's and neighborhood are viewed as interconnected systems with dynamic and reciprocal influences on the behavior of family members.
Motivational Interviewing. This is a person-centered, directive method of communication for enhancing intrinsic motivation to change by exploring and resolving ambivalence. *(Prescott, D. Evidenced Based Practices, OATSA. 2007*)

Sexual Behavior Management. PTCN's developmental tracking of sexual behaviors in youth is based on the work of Toni Cavanaugh-Johnson, Ph.D. and Rhonda Doonan, Ph.D. "Children 12 and younger with sexual behavior problems: what we know is 2005 that we didn't know in 1985" as well as Amanda Fanniff M.A. and Judith Becker Ph.D. "Developmental Considerations Working with Juvenile sexual offender" published in 2006 by Nerai Press edited by Robert Longo and David Prescott.

Trauma Remediation and Rebuilding Attachments. This work is informed by extensive training in understanding the physiological and neuro-developmental responses to stress, developing strategies for improved self regulation, attachment to caregivers, and improving executive brain functioning. *(Creeden, Kevin. "Trauma, Attachment, and Neurodevelopment—Implications for Treating Sexual Behavior Problems", 2005).*

Additional Principles in Treatment:

Responsibility: We believe that each person is solely responsible for him/herself. A big part of treatment is taking 100% ownership for what you think, feel, and do; this includes past behaviors, thoughts, and feelings. The way you take responsibility for your actions is by telling the group about what you have done in very specific detail, answering questions to the satisfaction of your group and therapists. Not only do you talk about your sexual history in detail but about everyday experiences at school, home, family, friends, church, etc...

Accountability: You are accountable for what you have done. Accounting for you is part of being responsible. Not only is it important to account for past behaviors but you must account for who you have become, a Sex Offender. You are in treatment to stop the process of becoming an adult sex offender. You don't have to stay a sex offender, you can become something much different---a person who is re-covering from a sex offender lifestyle and developing a healthy and responsible lifestyle. Accounting for yourself is hard; it involves a sifting of your thoughts, feelings, and beliefs with a willingness to accept your treatment group's perception of you.

Sickness of Secrecy: Secrecy is a core ingredient in the way you sexually offended, thought about what you wanted to do, and all the ways you protect your deviant sexual desires and urges. Eliminating secrecy from your past actions and what you're doing now is a primary treatment goal. Maintaining secrecy will prevent you from Trusting keep you wanting to sexually offend –endangering the community.

Dangerous Double-life: Double life is where the young person is able to fake or put on an appearance of "complying or working treatment" while at the same time is sexually offending, violating treatment contract, or maintaining deviant arousal (these are only a few). Double-life is one of the most dangerous things you can do to yourself and others in treatment. It will set you up to reoffend, make your treatment have little to no effect, you won't trust anyone, you'll set your self up to fail all your polygraphs and **No One Will Trust You!** Double-life is one reason you will take regular polygraph exams throughout your course in treatment. Except for reoffending, **Double-life will result in the most strict consequences in treatment.**

Polygraphy (for youth 12 yrs old and up): Lie detection exams will be routinely conducted on age appropriate youth to verify truthfulness of sexual history and currently level of sexual behaviors. Most youth were sexually touching other youth in previous programs and one way we reduce this behavior is to routinely engage in a polygraphy process. When youth know they are going to be tested on lying about sexual touching in the program they inhibit their urges to abuse each other. If youth are sexually abusing each other in program it is NOT SAFE and no progress with occur.

Victim & Community Safety: Victim & community rights/protection will always come first in your treatment at PTCN. Your rights and privileges will not come before those you have hurt or may potentially offend. This is a very difficult change in the offender's reality, since they are used to thinking "Me First" in most situations, especially with sex. All passes, phone calls, visits, activities, privileges, etc.... will take into consideration potential harm to others.

Risk of Reoffending: All treatment youth beginning the treatment process are at risk for reoffending. Levels of risk go up and down depending on what is going on in the child's life. Part of treatment is learning about your potential for reoffending and lowering the risk level to ensure community and victim safety. All decisions are made with the consideration of risk for reoffending.

Confrontation: This is a way of talking about the sexually abusive behavior with the youth who has engaged in offending. Since a youth is expected to take responsibility for his/her behavior, any statement short of this is dealt directly with the youth. We don't "beat around the bush" in treatment. We work at stating accurately what we see the youth doing. Likewise, we expect other treatment youth to directly talk with each other honestly and to hold other group members accountable when someone is avoiding responsibility. At first, this is extremely uncomfortable for new treatment program members and will take some time for adjustment. There are different levels of confrontation from light ("what about....?) to heavy ("this is what you did and what was wrong with it")

Group Therapy: In dealing with deviant/secretive/sexual acts, group treatment is one of the most effective ways in breaking the secret around sexual offending. It's not enough to tell just one person, because sexual offending hurts not just the victim but those close to the offender and victim. Group treatment provides larger accountability to more than one person, making it harder to get others into secret sharing alliances. Group allows for more than one perspective to be shared and considered. Additionally, talking about secrets and problems in a group makes it easier to see the flaws in thinking and what makes certain behaviors wrong.

Individual Therapy: This is time for the therapist and youth to be dealing with sensitive issues that the youth may not be ready to address in a larger group setting. At some point though, it is expected the youth will be able to disclose individual session material to his/her group members. Individual therapy allows more opportunity to work in a detailed and more focused manner on deviant sexual impulses, fantasies, arousal patterns, victimization trauma impact, ect...

Family Therapy: This is time for the family members to get some of their treatment needs met with out the whole community looking on. Initially, dealing with the trauma of the child's disclosures is a primary issue since many people who have been hurt now begin to be identified. This is a shock to the whole family system and time is needed to slowly work through the betrayal, anger, depression, grief, shame, and need for additional offense specific information. Once the youth and family have completed clarification, other family issues are worked on that contribute in some way to the predisposing and perpetuating risk factors for reoffending.

Proctor/Foster Parent Consultation: We believe that the supervising family of the offending youth will need weekly support and consultation on a variety of risk for reoffending issues and day-to-day behavioral management. Time before each group session is dedicated for those supervising parents to talk and share openly, get feedback, insight, and ideas from the therapist and other parents. This time allows for debriefing the previous time period after the last group session concerning the youth and case coordination. Time is also taken for monitoring treatment program integrity, consistency, and predictability.

Treatment Team: The Treatment Team is a critical element in effective treatment services to youthful offenders. The Treatment Team is made up of: Caseworkers, Parole-Probation Officers, Parent-Guardians, Proctor-Foster Parents, School Counselor, Church Pastor, CASA Workers, Family Members involved in treatment, and the Youth. The Treatment Team reviews the youth's work and progress.