

Focused Foster Care for Children with Serious Sexual Behavior Problems

Robert J. Jones, Mark A. Ownbey, Julie A. Everidge, Bonnie L. Judkins, and Gary D. Timbers

ABSTRACT: Properly implemented, foster family care may represent a uniquely appropriate placement/treatment alternative for young children with pronounced or dangerous sexual behavior problems. A few programs have reported preliminary but promising results with such children in fostering environments specifically designed to address their special problems. This study details the salient components of one such program that has proven successful over the past six years with most of thirty youthful clients referred to it facing few alternative placement options. Rankings by program staff and program parents of the relative importance of ten program components to client success are reported, and updates on previously published outcomes with the first six clients to enter the program are offered. Subjective but important “lessons learned” by staff and parents about working with this difficult population in the fostering environment are also discussed.

KEY WORDS: Foster care; Children; Sexual behavior problems.

Social work professionals are increasingly recognizing both the reality of serious sexual behavior problems among pre-pubescent clients and the special dilemmas that surround the appropriate treatment of them when they are removed from their families and referred for placement. Older youth presenting the same problem behaviors have historically been directed by the courts –advisedly or not– into

Robert J. Jones, Mark A. Ownbey, Julie A. Everidge, Bonnie L. Judkins and Gary D. Timbers are affiliated with Appalachian State University, Boone, NC, USA.

Address correspondence to Robert J. Jones, Appalachian Family Innovations (formerly BIABH Study Center), 203 Avery Avenue, Morganton, NC 28655, USA; e-mail: bob.jones@familyinnovations.org

secure, institutional treatment. But secure congregate care facilities, with or without cogent special programs for sexualized or offending clients, are clearly not viable for 8- and 9-year-olds. Also, because these children often present a threat to other children, group residential care of any kind is not an appealing option. (Nor is it, we would point out, with similar adolescent clients for the same reason.)

The management and efficacious treatment of these children within the foster family framework has not been widely attempted. However the past half-decade has seen the emergence of several efforts on this front and the occasional publication of their early results. Social work professionals in the UK have tended to explore the fostering alternative with these clients more aggressively than has been done in the US (Farmer & Pollock, 1998, 2003). There has been gathering recognition here in the US that foster care may present numerous and significant advantages over residential or institutional care for these special clients for reasons of intervention quality as well as cost (Barth, 2001). One of the first studies here to report specifically on the effects of a foster care program for young children with problem sexual behaviors concerned itself with the global behavior progress of its clients rather than with their sexual behavior-specific improvement (Ray et al., 1995), but that study opened a conceptual door.

More recently, Ownbey, Jones, Judkins, Everidge, and Timbers (2001) have reported the effects of a specialized program of foster care on both the frequency of problem sexual behavior and foster care giver estimates of the propensity to re-offend (a measure of treatment internalization) of six initial clients referred to a treatment-intensive foster program for sexually reactive children and sexually aggressive pre-adolescents. That study concerned itself more with preliminary client outcomes than with the details of the program elements that were brought to bear on the clients whose data were presented.

The present report is an extension of the Ownbey study, and its primary purpose will be to provide an overview of the key components that constituted the design and subsequent implementation of a foster family-based program specifically focused on the treatment needs of children with serious sexual behavior problems. The program, for want of a more ambiguous name, is called the Intensive Program, and it continues to operate and grow as a variant of the

Professional Parenting Program of Appalachian Family Innovations, which operates under the auspices of Appalachian State University in North Carolina.

Beyond a description of the components of the Intensive Program, we will also present rank-order data solicited from both program staff and program parents concerning their opinions as to the relative importance of the ten program components described to observed client successes. Additionally, this report will offer an update on the current circumstances of the six clients of the original study and extended data, following the initial protocol, on one of those clients who remained available for long-term study. The report will conclude with a discussion of seminal lessons program staff have learned about how best to address the needs of this population in the context of focused foster family care.

Brief History of the Intensive Program

Professional Parenting has provided treatment-oriented foster care to special needs clients in several North Carolina population centers for almost three decades. The program custom designs fostering protocols for children whose treatment requirements exceed the capabilities of the county agencies from whom those clients are referred. In the mid-90s the program received a request from a social services agency in its operating area for guidance with several children in its custody with significant sexual behavior problems. Money problems were explored and solved, program staff hit the books to research—and then the road to visit—existing programs for similar clients (all institutional and all for adolescents), and the Intensive Program was conceived and then implemented.

The initial design of the program was based on the view that, minimally, the first requirement of any program aiming to treat clients who might be sexually dangerous to others was that it be able to interrupt or contain the aberrant sexual behavior of its charges, whatever their age. A second goal of the program was to produce enduring changes in the clients' future likelihood of repeating past sexual offenses. Preliminary results (Ownbey et al., 2001) indicated both design objectives were met.

The Intensive Program and its Core Components

While we will later review the opinions of program staff and parents as to the relative importance of the key program components described below, the order in which they are summarized in Table 1 and discussed here is simply the order in which they were originally contemplated.

Selection and Training of Program Parents

Earlier experience with other special needs clients (e.g., Jones, Judkins, & Timbers, 1989) suggested to program staff that program parent selection and training would be the first and most vital task.

Selection

Family configuration, the ability to absorb and benefit from the specialized training that had been developed, and the wherewithal to implement vigorous monitoring and management tactics were the primary markers for selection. Several specific requirements for program parent eligibility included the following: (1) all eligible families

TABLE 1

Program Components in the Approximate Order they are Implemented

Program component
Selection and training of program parents
Matching of clients with program parents
Program manager visits to the family
Available 24/7 phone consultation by program managers
Comprehensive safety planning and monitoring for client
Group educational sessions with clients
Group educational sessions with program parents
Normalizing/stabilizing effect of the fostering environment
On request respite services
Extra-program counseling, testing, or other community services

had to successfully complete the same licensing requirements (home study, home inspection, reference checks, criminal background checks, etc.), mandated by the State Division of Social Services for all foster parents; (2) each prospective parent had to successfully complete the six-session, 30-plus hour, general training protocol of the Professional Parenting program; (3) in two-parent household units, one partner had to devote full-time to program responsibilities, i.e., only one parent could work outside the home (As compensation for this level of treatment and training effort, the program provided \$1,500 per month stipends to all program families.); (4) in addition to the general training mentioned above, both parents had to complete the specialized training (see summary below) associated with the Intensive Program; (5) eligible families could have no young or otherwise sexually vulnerable children in the household; (6) the families' homes had to be large enough to afford the placed client a private bedroom; (7) at least one parent of each pair had to commit to attend weekly Parent Group educational sessions (see below); (8) one or both of the parents had to be available to attend extra-program family services or mental health therapy sessions as requested by the extra-program therapists involved; (9) both parents had to commit to the provision of vigorous supervision and monitoring of the placed client as specified by the family's Program Manager, outside therapists, or multi-member treatment team, and; (10) both parents had to agree to comply with a list of program policies and procedures as specified in a written Agency Agreement statement signed by the parents and by an agency representative.

Training

Those parents who met the above selection requirements were qualified to proceed with the specialized training protocol designed to help them work with program clients with pronounced sexual behavior problems. While space does not permit a detailed description of that training, it is organized around four primary training topics: Normal Development, Sexualized Children, Attachment Issues, and Treatment and Safety Planning. Included among specific sub-topics of the training are: (1) the history of the Intensive Program; (2) a description of the characteristics of children who exhibit serious sexual behavior problems and factors that motivate their behavior; (3) a discussion of the kinds of birth homes and learning histories these

children commonly emerge from; (4) a discussion of the treatment focus of the program; (5) a consideration of target exiting plans for the clients (typically involving either continued placement in long-term foster care, adoption, or reunification with birth family members); (6) a thorough review of the cooperative relationship between program parents and their Program Managers as partners in the design and implementation of individualized client treatment and safety plans, and; (7) the requirement of professionalism on the part of program parents.

The latter training topic, professionalism, warrants elaboration because it is particularly emphasized during the Intensive Program training. Among other things, this aspect of the training addresses: (1) the high level of commitment required of program parents who live and work with these particular clients; (2) the importance of placing the clients' needs before those of the foster parent; (3) the necessity of persistence with these clients—the problems of the children are not quickly or easily reversed; (4) the importance of a professional approach to dealing with social workers, school personnel, therapists, birth families, and others outside the program; (5) the reality that all parents teach all the time by their own behavior (i.e., via modeling); (6) achieving the difficult balance between structure and nurture with program clients; (7) the necessity of careful monitoring, supervision, and consistency with these clients; (8) the importance of fully open and honest communication between parents and Program Managers (difficult problems will arise, parents will make mistakes, but Program Managers need to be informed of problems and of parent missteps); (9) the hard lesson not to take the clients' behavior personally and react negatively, and; (10) overcoming the tendency to minimize the seriousness of these children's sexually reactive or aggressive behaviors. We will re-visit some of these points in the subsequent section on Lessons Learned.

Matching of Clients with Program Families

This parameter of the program was based on the longstanding experience of the Professional Parenting program that child clients do not necessarily do equally well with any available foster family. The Intensive Program arranges trial weekend visits by referred clients with prospective foster families, followed by independent interviews with both the client and the family concerning preliminary feelings

relating to subjective things like fit, comfort, and fun. Staff look for clear signs of potentially strong or, conversely, potentially problematic matches. In the latter case, of course, a visit by the client to an alternative family is scheduled. (This procedure clearly depends on a continuing pool of qualified and eligible families. That ideal is difficult to accomplish because family recruitment remains the most persistent obstacle facing this special program as it is in foster care, generally.)

Program Manager Visits to Foster Families

The Intensive Program requires at least weekly visits by Program Managers to foster family homes. These visits include time with both the program parents and with the child clients. Initially, these visits focus on treatment and safety planning (see below). Subsequent visits are mainly concerned with monitoring but may also be aimed at adjustments in either treatment or safety plans and often involve situational problem solving.

Available 24/7 Phone Consultation by Program Managers

In addition to the weekly in-home visits just described, all program families are invited to call their Program Managers any time they need help or guidance, night or day. Such calls may involve crises with clients or simply family support needs. Program staff are expected to travel to the home of program parents if client difficulties require their assistance there. In practice, such emergencies are infrequent. Backup program staff are always available when an assigned Program Manager is unavailable.

Comprehensive Safety Planning and Monitoring

Client "Safety Plans" are the core of the program. These are constructed either at the time of placement or, ideally, before placement by the client's treatment parents and their Program Manager, and become part of—not a replacement for—the client's broader, more conventional treatment plan. The safety plans, and the discussions surrounding them, focus on several important things relating to the client's goals and also to the family's success with the client. They set the tone for addressing "touch" issues directly. They clarify the

role of supervision and monitoring for the family and the child. They focus on individualization in terms of the child's needs and the family's wherewithal to meet those. They convey to the parents that things for the client will be very restrictive at first and then relaxed as the child shows progress. The safety plans are specific, comprehensive, and involve observable (i.e., verifiable) events, e.g. "___will not leave the yard or enter the garage without permission." They are cast in child-friendly language, adaptable to settings outside the home, and are put forth in a written contract agreed to and signed by the child, the program parents, and the Program Manager. Safety plans are updated regularly, formally reviewed by senior staff quarterly, and are periodically relaxed as the clients' behavior warrants that. Program safety plans are written with specific attention to at least the following dimensions of the client's routine care: (1) sleeping arrangements; (2) bathroom arrangements; (3) appropriate touch; (4) inappropriate touch; (5) television/radio/movies/magazines; (6) the client's freedoms outside the home; and, (7) client behavior in respite care and in school and other public settings.

Beyond the primary program family, safety planning actively involves other adults in the community who have regular contact and involvement with the client including school teachers and administrators, school bus drivers, YMCA staff, and others. Confidentiality issues surrounding the involvement of such individuals in client safety planning and monitoring are approached carefully and thoughtfully. Client information shared with community participants is limited to what they may need to know to participate responsibly in the process.

Group Educational Sessions with Clients

Other organizations choose to call group sessions with similar clients "psycho-educational group meetings." Our program staff agreed that our aim is to teach and, thus, now designate these sessions as group educational meetings. They involve all program clients of both sexes in the approximately same age range. These weekly group meetings are conducted by two Program Managers, called "co-facilitators" in that role. The clients assemble around a table at the program office and are invited to offer their impressions on various of the following topics: making smart choices; thinking errors; planning for success; problem solving; understanding my feelings and behavior;

behavior management; sexuality and our bodies; families and relationships; life books; past and present behaviors; accepting responsibility; helping others/empathy; healthy behaviors; feeling good about myself/positive self-esteem.

Clients are periodically graduated from regular group participation when the group facilitators and the client's Program Manager feel the client's behavior reflects an assimilation of the informational content of the group process. Such "graduations" are purposely surrounded by a degree of ceremony and celebration, and clients thus graduated are encouraged to visit subsequent group sessions whenever they like (and they often do).

Group Educational Sessions with Program Parents

Unlike the group sessions just described for clients, similar sessions for program parents (conducted concurrently with the client groups and at the same location) follow planned agendas but are less formal and often, as they have evolved, tend toward interpersonal support among the program parents. They are typically conducted by a single Program Manager and, while program staff have chosen not to rigidly require the attendance of all program parents, an expectation of regular attendance by at least one of each client's foster parents is clearly conveyed.

Scheduled topics for the parent groups correspond with the topics being covered in the corresponding client group but are also aimed at supporting the content material in the home the following week. Parents are encouraged to use the same language at home with their clients as the staff use with clients in their group sessions. Additional parent group content has focused on areas such as "red flag" behaviors, attachment issues, behavioral techniques, birth family issues, school and other out-of-home progress and problems, medications, and ongoing client assessment, among other topics.

Normalizing/Stabilizing Effect of the Fostering Environment

While this aspect of the Intensive Program cannot be cast as a distinctive or defining component of the Intensive Program, all of the program staff feel it has contributed to the successful outcomes of its clients. The vulnerable children served by this program come, predictably, from biological families in crisis or chronic chaos. Part of

becoming competent in all life tasks involves a child observing those behaviors in the adults around him or her. The Intensive Program attempts to ensure that modeling. Additionally, the opportunity for clients to learn and develop in a stable, normal home environment underlies the concept of the program.

On Request Respite Service

The program provides for traditional respite for program parents two weekends each month or on an as needed basis. All respite parents are given the same training and other preparation as primary program parents. (More recently a special program of "therapeutic respite" has been implemented to help program parents cope with particularly difficult client behavior issues [results in preparation], but this article is concerned only with the provision of conventional respite care.)

Extra-Program Counseling, Testing, or Other Community Services

Again, while this aspect of intervention was not considered part of the primary programming, it was deemed relevant to this discourse. Most of the original and subsequent clients were referred to the program with existing arrangements with mental health or other certified counselors (often mandated by the referring agency). These individuals provided counseling and other often unspecified services but were routinely included in program team meetings. The effect of the involvement of these professionals remains uncertain.

Program Staff/Parent Rankings of the Relative Importance of Program Components

The Intensive Program is complex and multifaceted. Program staff and parents recognize that the program's various individual components are not likely to be equally important to individual client outcomes. In an effort to elucidate the relevance of the program components we requested both the current contingent of program managers and senior program staff and the current group of program parents to respond to a simple survey asking them to rank the 10 program components described above as to their relative importance to favorable client outcomes.

Survey Method

Ten Program Managers and senior staff and 33 program parents completed single-page instruments that listed the ten program components shown in Table 1 preceded by brief but specific instructions about the completion of the ranking survey. The instructions emphasized that "... we are interested in your ranking of the importance of these program components on the clients' *sexual behavior problems*, not on other emotional or non-sexual behavior problems our clients may have." Program parents and staff completed the ranking surveys in private and returned their completed instruments to the program research office by mail.

Results

The results of the ranking survey are shown for the ten Program Managers/Staff in Table 2 and for the 33 program parents in Table 3. Each of these tables indicate the mean rank, range of rankings, and standard deviation for each of the ten program components included in the survey and described in this study.

Returns showed considerable variability among Program Managers and among program parents as well as differences in mean rankings between the two groups. Notable consistencies in the rankings, however, include the following. (1) Both program staff and program parents, on average, ranked *safety planning and monitoring* of greatest importance to client outcomes among the 10 components on the survey. (2) Additionally, while the order of their rankings differed, both groups of respondents, on average, placed three other program components within the top half of their ranking lists. These were *selection and training of program parents*, *program manager visits to family*, and *normalizing/stabilizing effect of the fostering environment*. (3) There was also consensus between the groups, on average, that *extra-program counseling and other services* were least important to client outcomes relative to the other nine components.

While we hope these data are illuminating, the authors would caution that each of the program components discussed in this report may be of critical importance to some clients at some point in their treatment. Program staff have not chosen to dilute or

TABLE 2

Program Components Ranked on Importance by Program Managers and Senior Staff (n=10)

Program component	Mean rank	Range	SD
Comprehensive safety planning and monitoring for client	1.4	2	0.69921
Program manager visits to family	2.7	3	1.15950
Selection and training of program parents	3.7	6	1.88856
Normalizing/stabilizing effect of the fostering environment	5.7	7	2.26323
Group educational sessions with clients	5.8	7	2.34758
Available 24/7 phone consultation by program managers	5.8	8	2.25093
Matching of clients with program parents	6.4	6	2.59058
Group educational sessions with program parents	6.7	6	1.88856
On request respite services	7.3	6	2.11082
Extra-program counseling, testing, or other community services	9.5	5	0.84984

eliminate any of these 10 program features based on the data just described.

Update on the Six Clients of the Original Ownbey et al. (2001) Study

Several of the six clients who were the subjects of the earlier Ownbey et al. (2001) study have left the official purview of the Intensive Program. Program staff have, however, remained in some level of touch with all these former clients through their various foster or adoptive parents or other care givers, and the recent circumstances of these clients are summarized below.

TABLE 3

Program Components Ranked on Importance by Program Parents (n=33)

Program component	Mean rank	Range	SD
Comprehensive safety planning and monitoring for client	3.3	8	2.51849
Selection and training of program parents	3.8	9	2.81769
Normalizing/stabilizing effect of the fostering environment	4.6	8	2.06063
Matching of clients with program parents	4.8	9	2.82977
Program manager visits to family	4.9	8	2.03770
Available 24/7 phone consultation by program managers	5.6	9	2.42423
Group educational sessions with clients	5.9	9	2.49989
On request respite services	6.0	8	2.27053
Group educational sessions with program parents	6.3	9	2.83901
Extra-program counseling, testing, or other community services	8.7	6	1.82833

One of the original clients is now in the process of being adopted by her program parents and that family unit has remained accessible for data collection, using the original research protocol, for a period of 4 years beyond the previously reported 2-year data gathering interval, i.e., for a total of 6 consecutive years. The data resulting from this opportunity are illuminating both because they tend to persistently parallel the basic 2-year data pattern exhibited by all of the study's original clients and because they portray a remarkable success story for this female client who came to the Intensive Program at age 8 with a profound history of physical abuse, sexual abuse, and neglect. We described this client in the earlier study as "... (presenting) significantly more serious sexual behavior problems than did the other five children (in the original client group)."

While we will briefly summarize the method and point of the previous study here, we would strongly commend the reader to the original study (Ownbey et al., 2001) for details concerning the conduct of that study and for the Client Profile information offered in Table 1 of that report.

Summary of the Method of the Original Study

Briefly, Ownbey et al., (2001) gathered pre-treatment base point data and subsequent in-treatment data at 3-month intervals from care givers/program parents concerning two dimensions of each clients' unfolding sexual behavior pattern. These were the observed or suspected *frequency* of sexual problem behaviors, and care giver/program parent predictions "at each data gathering interval" as to their best estimates of the *propensity* of the clients to re-offend in the future, "... given free opportunity, an available victim or target, and complete privacy or other protection from discovery and/or consequences."¹ We characterized the latter dimension as a "... crude measure of treatment internalization" For each client, we gathered individual frequency and propensity data for as many "offense constellations" (victim or target categories) as that client presented at the time of referral to our program. For example, the client "profiled in the original study as 'Client #1'" whose long-term results are presented below came to the program with a pronounced history of sexually inappropriate or offending behavior directed at other children (younger and older), adults, and pets. Thus, two sets of data, frequency and propensity, were gathered for each of the individual clients' offense constellations. Thus, in the case of original Client #1 who presented three offense constellations (children, adults, and pets), six sets of data resulted.

Extended Results for Client #1 of the First Study

While data for the six client subjects of the original study were presented in tabular form to conserve journal space in the original

¹The words "offend/offense" and "re-offend" are used here simply in reference to sexually inappropriate client behaviors and to the subsequent repetition of those behaviors, respectively. They are used for the sake of continuity with the earlier study and are not intended to otherwise characterize the clients or to imply judicial interventions with them.

study, the data produced over 72 months for Client #1 are depicted here in the six charts shown as Figure 1. The charts to the left of the figure reflect data gathered on the *frequency* (per week) dimension for each of this client’s three presenting offense constellations or victim targets. The charts on the right of the figure show corresponding *propensity to re-offend* predictions for each of the client’s three offense constellations. The “BP” at the left on the horizontal axis of each chart represent this client’s pre-treatment Base Point data gathered from the client’s caretakers immediately prior to her referral to the Intensive Program.

These data are notable in three respects. First, the problem sexual behaviors of this child (shown on the frequency side of the figure) persisted significantly longer than did those of the other client

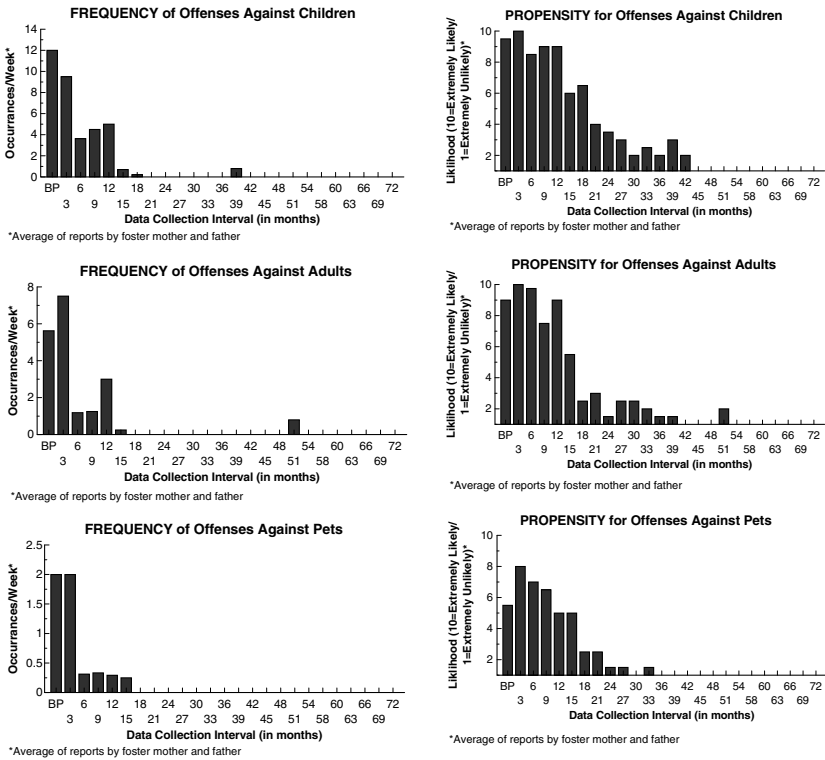


FIGURE 1. Frequency and propensity to re-offend against children (upper), adults (center), and pets (lower) by Client #1 over 72 months.

subjects of the original study. This client's problem sexual behaviors were not fully contained (notwithstanding the isolated events at month 39 with children and at month 51 with adults – the term “spontaneous recovery” comes to mind), until her 18th month in the program. Second, her parents' continued to predict that she might re-offend (shown on the propensity side of the figure), albeit at decreasing levels of confidence about this, until over 3 years (in the case of child and adult targets) after the child's initial admission to the Intensive Program. Third and most important, this extraordinarily compromised child, thanks to the precepts of the Intensive Program and the remarkable care of the exceptionally skilled program parents who later adopted her, has proceeded into adolescence relatively free of difficulties concerning her sexual behavior. We discontinued collecting data from this child's parents when it had been over a year since their last report of sexual behavior incidents or of even low level predictions by her foster parents that she might re-offend given the opportunity.

Update on the Other Five Clients of the Original Study

With the exception of Client #1 just discussed, program staff have remained in formal and regular contact with two of the other original clients (Client #2 and #4) but in only occasional and informal contact with the other three client subjects of the original study. Again, the summary outcomes of the other initial clients described below become relevant only after one has reviewed the detailed Client Profiles presented in the earlier study.

Client #2, a girl who entered the Intensive Program at age 10, is now 18 and continues to live with her original program parents. They report she is doing well as she enters young adulthood and evidences no continuing sexual behavior problems.

Client #3, entered the program at age 12 with a high rate of sexual behavior problems involving multiple victims including his younger sister, also a program client, and pets. This client remained with his original program parents, relocated with them to another state, and graduated from public high school there recently. Currently he is gainfully employed and contemplating military enlistment. No further sexual behavior problems have been reported.

Client #4, entered the program at age 8 with a history of consenting sexual involvement with her brother, Client #3, as well as

offenses against other children and adults. This child has also remained with her original program parents on a fostering basis and 2 years ago began public high school in special classes. Her parents report occasional problems involving the child's access to internet sexual material and the sending/receipt of sexual e-mails. No public sexual behavior problems have been observed or reported, however, and the child is otherwise doing well.

Client #5 was the program's only technical failure in that the program was not able to contain this child successfully in placement. This male client was referred to the program at age 9 with a significant history of offenses against children, adults, and pets. After 2 years in the program this client was referred out of our program to a mental health foster family. His placement there disrupted owing to various non-sexual problem behaviors (e.g., breaking curfew, cursing family members, using illegal drugs, truancy, etc.). Before we lost track of this young man he had proceeded to an emergency home in another city and was later involved with the legal system for destruction of property. Not surprisingly, the propensity to re-offend data reported by his last program family indicated that he remained very likely to re-offend against all of his initial target/victim constellations by the end of our 24-month data gathering period.

Client #6, a male client, entered the program when he was 11 years old. This client was adopted by his program family and moved to a distant state, but that family has occasionally visited us with the former client and has reported that he has recently graduated public high school.

Lessons Learned Over Eight Program Years

The above described children, and –more than 20 subsequent clients– have presented multiple and very difficult problems, program staff and program parents have been energetic and creative in dealing with those, and there is a collective sense supported by the data presented here and earlier that the Intensive Program is making a favorable difference in the lives of the special children it has chosen to serve. But the work and the learning doesn't end. Quiet lessons are learned informally, continuously, and sometimes subtly.

The staff of the Intensive Program, aware that this report was being prepared, agreed to gather to discuss some of their subjective

impressions about the program, its strengths and its complications, during their involvement with it. The thrust of their observations ought to be critically relevant to any agency wishing to attempt to replicate our Intensive Program. The lessons are these:

Most young clients who are referred with serious sexual behavior problems also come with what are called pronounced attachment issues.

Those clients commonly present difficult non-sexual behavior problems that are much more difficult to manage than their sexual difficulties.

Program parents, despite the best efforts of program training staff and managers to disabuse them of their misconception, never fully believe that program clients have serious sexual behavior problems *until* they actually see or otherwise encounter these problems. (When that happens, as it always does with these clients, program parents invariably register sincere surprise.)

Similarly, most adults who are invited to participate in the client's safety plans (teachers, bus drivers, YMCA staff, and even counselors and therapists, etc.) are often not initially convinced that these children can/will engage in serious sexual behaviors that endanger others (again, until they witness or learn directly of such behaviors).

Children referred to the Intensive Program, not surprisingly after brief contemplation, have often arrived as sibling groups. The program's initial temptation was to place those children with the same family. Wrong! Our now wiser and more experienced recommendation is don't, ever! Whatever other sexual behaviors these sibling clients may be involved in, they have proven almost invariably to be engaging one another, either consensually or not, in inappropriate sexual acts.

Get all the referring information you can on referred clients and then treat that information skeptically. Agencies encountering these difficult clients are often at the bottom of their placement resource barrel and are prone to minimize client problems, particularly in the area of aberrant sexual behavior.

For program staff, know and expect that your perspective on children and their behavior together will change. This is a difficult point to convey but an illustration may be helpful: The following is a quote from a Program Manager to a member of the research staff: "I used to be able to watch a group of children

playing together with happy feelings and indifferent abandon. What fun! But (after working with our program clients) I can't do that any more. I watch much more closely now. I always wonder, and I often worry." (Similar reactions have been differently stated but pervasive among our program staff.)

Last, though our list continues to grow, program staff advise vigorous efforts to include and educate collateral professionals as to the program, its methods, and its intent. Notwithstanding data presented above relating to *Extra-Program Counseling, Testing, or Other Community Services*, program staff concur that a team effort is essential to the recovery of these difficult children.

Summary and Conclusions

Young children emerging from sexualized or otherwise problematic family environments are fully capable of engaging other children (not to mention adults and animals) in serious and age-inappropriate sexual activities. These children present a difficult and increasingly apparent placement and treatment problem to society and, thus, to those of us in the social work profession. Congregate care, especially in institutional environments, is clearly the wrong approach with these clients.

This study has described the core components of a focused foster family-based treatment program, called the Intensive Program, and has attempted to convey both its strengths and weaknesses. Additionally, this study has offered updated outcomes, in one case extensively, of the six clients involved in a previously published study. Last, the study has attempted to offer thoughtful lessons learned based on the cumulative experience of dedicated program staff working daily with the complex problems of these special children during the past 8 years.

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