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**Jimmy Widdifield, Jr.:**

Hi and welcome everyone. My name is Jimmy Widdifield, Junior. I’m a program manager with the Oklahoma Commission on Children and Youth, and I’m here to have a great conversation today with two friends and colleagues of mine. This series is intended to just get more voices out there on how we help children with problematic sexual behavior. Today I’m really fortunate to get to talk to two great people - Carrie Jenkins and Julia Grimm with the Dee Norton Child Advocacy Center in Charleston, South Carolina. I’ve known both for about 11 years now, but I’m looking forward to creating some new stories today, so I’ll give a chance for both to introduce themselves. We’ll start with Carrie and then go to Julia.

**Carrie Jenkins:**

I’m excited to talk today and laugh probably. I’m Carrie Jenkins, and I work for Dee Norton Child Advocacy Center and have for the majority of my career. I became involved in the PSB program when I was an intern, actually, and got trained in the treatment modality - the adolescent program. Then I worked at a sister agency, Dorchester Child Advocacy Center, for about a year and a half, putting that program together essentially - or helping support it rather - and then moved back to Dee Norton. I’ve been in a couple different roles, both direct service, doing therapy and forensic interviewing and helping build our program. Now I’m in a supervisory capacity, but also staying really intimately involved in our PSB program. Then, about five or six years ago, I became part of the University of Oklahoma Training and Technical Assistance team for PSB-CBT in both adolescent and school age. It's a real passion area of mine, and I’m excited to get to chat about it today.

**Jimmy Widdifield, Jr.:**

Thanks, Carrie. You could tell that she was starting to do the acronym introduction and caught herself because Carrie could certainly, I think, give us her entire professional history all in just letters. I love it, so thanks for that, Carrie. Julia, what about you?

**Julia Grimm:**

My history is very similar to Carrie. She and I have really grown up in this field together and people joke that we share a brain. I also started at Dee Norton Child Advocacy Center as an intern 12 years ago and I never left. I’m still here. I got trained in the adolescent PSB-CBT model as a student and then, staying on at Dee Norton, got trained in the school age and preschool models of PSB-CBT. I’ve been involved in that program pretty consistently my entire career here at Dee Norton. I have, like Carrie, served in several different roles. I’ve been a therapist and forensic interviewer and have done events and prevention programming. Then, along with Carrie, five or six years ago, became a trainer in the school age and adolescent PSB-CBT models. I’m also a clinical trainer in risk reduction and family therapy. I have a real passion for working with youth and a real passion for teaching and training. I’m excited to be on this podcast and to talk about some things that we’re super passionate about.

**Jimmy Widdifield, Jr.:**

It seems so strange we've known each other for this long. I was part of the training project there in South Carolina for the school age and preschool parts of that community-based learning collaborative. I came in about a year after the training for the adolescent model happened. In that particular learning collaborative, which was the first of its kind, I think it's important to note that, prior to the training in South Carolina, the training and technical assistance team at the University of Oklahoma National Center on Sexual Behavior of Youth (prior to that learning collaborative) there was no standardized way of training other agencies or clinicians. There was only one other place outside of Oklahoma City that had been trained in all three models. That's the Children's Advocacy Center in St Louis, Missouri. And they were trained by someone who came from the program in Oklahoma there, so you were really the first. And that model has been adapted since then, has morphed into what's being used today to train all across North America. Even in Calgary, Alberta, Canada, in Bristol, England and other places. I’m wondering if we could start our conversation with what you know, or what was the catalyst there in the Charleston community that led Dee Norton to take steps to address the issue of children with problematic sexual behavior. And maybe we'll start with Julia, if you want to give your thoughts, and then go to Carrie.

**Julia Grimm:**

Sure. So, really, it was based out of a CAC. We were seeing several families where there was youth initiated problematic sexual behavior and our multidisciplinary team didn't really know what to do with the families of the initiating child or with the initiating child themselves. We had TF-CBT (Trauma-Focused Cognitive Behavioral Therapy) available—for the impacted child and their family. But we didn't have a lot available, really anything, that was evidence-based or evidence-supported available for the initiating child. What we recognized was so often these cases are intrafamilial, where both children are in the same family. We also recognized that, consistent with the existing body of research, about a third of child sexual abuse cases involved initiating other youth. And that was a large portion of the families we were seeing. We didn't have a good solution for how to safely serve, how to maintain community safety and familial safety, and facilitate healing and forward movement for those families. So that was really what we recognized—the need and the catalyst to bring in a community-owned intervention to be able to move these families forward.

**Jimmy Widdifield, Jr.:**

Carrie, what do you want to add to that?

**Carrie Jenkins:**

I think Julia covered a lot of it. The only other thing that she and I were sort of hypothesizing or wondering about is that we, as a CAC, function a little differently than some CACs. So, a lot of CACs really only engage with families when there's law enforcement or DSS that's referring to them. They have that requirement of a Community Partner being involved and we've routinely, since I’ve been here at least, have always allowed for really any type of referral. A family member could be concerned and would call us. We might get involved with a school. There are lots of different options for people who may want to make a referral or have concern about some sort of abuse to a child. And I wonder if, maybe, we were a little ahead of the game because of that fact, because so often these cases can fall through the cracks if we're counting or relying solely on law enforcement or DSS to be involved. There are a lot of reasons that they may not get involved. I mean, it may not be a prosecutable case, in which case law enforcement really doesn't see that they have value if they're not going to be pursuing a bad guy and charging someone. And DSS may not get involved or see a need for them to be involved if there's not a parent who is behaving in a way that endangers a child, and so on. A lot of times these cases can fall through the cracks of the system, and we didn't have cracks. We had a means for these cases to come before us and to really see the need that has always existed, but maybe we were able to see it in a way that others weren't until later.

**Jimmy Widdifield, Jr.:**

So, as you're both speaking I’m thinking back to when you were just introducing yourself a couple minutes ago—you both talked about having a passion. And we would be in serious error if we didn't mention Libby Ralston, who was the executive director of Dee Norton at the time of training 10-11 years ago and Alyssa B. Caesar. These two administrators were driving this change in your community. Carrie, you and I recently were talking about Libby. But really how Libby just made this kind of a passion project, for lack of a better word. I just wanted to point out that you both talked about this being a passion for you, and just recently talking about that was the same for Libby, and it just became that priority.

**Carrie Jenkins:**

I was just going to say, I think that passion is really sometimes necessary. I mean there is a lot of times, I think, CACs view this as an add-on or an additional piece of our mission. And I think it was really Libby who instilled in us that it's not. It's one and the same. These are our kids, and we need to find services for them in the same way that we would serve all of our kids, so it's not an add-on. I think that framework was really pivotal for our whole community to embrace, embrace a way of approaching this as not additive, but rather for each discipline, a mandate. We had to figure out what to do with these kids to serve our mandate of helping children, so I think we have her to thank for that approach.

**Julia Grimm:**

I 100% agree with that. I also just really internalize a framework of work with PSB being primary prevention and to be able to see, to conceptualize these youth and children as dynamic and in a very dynamic stage of change in terms of development and to conceptualize what we think about how PSB develops, where it develops. A lot of these kids, not all of them, but a lot of them, have sometimes various trauma histories, exposure to domestic violence, coercive controlling home atmospheres, and sometimes sexual abuse, though not as often as people might think. And we were already seeing these kids, we were already seeing these families. They were already in our lobby, they were already being referred for forensic interviews, for other things sometimes, and we would discover the problematic sexual behavior. At the time Carrie and I were students, Libby and Alyssa B. were real trailblazers in saying, “Hey where better to serve these youth than the CAC with our coordinated community response and existing resources?”

**Jimmy Widdifield, Jr.:**

That's a great segue into kind of the next place I want to go. First, I do want to say I just I love hearing you both talk, because you are hitting on what we know from the research, right? And I think that's just another thing to extract here for people who are listening, is that this is not kind of what we think we know, this is what we actually know, and to hear you just exerting that, I mean, is just fantastic. I do think several people are probably clutching their pearls right now thinking, you know, Julia, when you said, “Well these kids were in our lobby.” I’m sure they're just like, “What do you mean they were in your lobby?” But your point is well taken, the CAC was already serving these kids, maybe not formally, but these kids are coming in the door, because that's the mission of the CAC—helping children. I wonder if you would share with us a little bit about how the MDT there at the children's advocacy center approaches these cases and the program. What's their perspective, what's the MDT doing with these cases and to support the clinical work that you're doing?

**Julia Grimm:**

I’m going to let Carrie take this one. She’s had more involvement with the community change team process than I have.

**Carrie Jenkins:**

The MDT, I think, is really pivotal with these cases. We have a separate multidisciplinary team meeting that takes place every other week, and we have our usual core members, except slightly different. Dee Norton and then the sister agency that I mentioned, Dorchester Children's Advocacy Center, which is right down the road from us, we work really closely. This program is a community-owned program so neither CAC is the owner of the program, and so we work really closely together to make sure that the decisions that we're making are made on behalf of the program itself. Neither of us is unilaterally changing things related to the program so that there's that consistency across geographic location. Families experience the same intervention, regardless of who might be providing it, and that's really important to us. The MDT is a huge part of that, so us and Dorchester Children's Advocacy Center meet, like I said, at that biweekly meeting for the MDT. Other members that are really consistently involved in that are going to be our family court solicitors or prosecutors. So, the people who, from the court’s perspective, are responsible for these cases if there is a juvenile charged or child charged in this. In addition to that are our public defenders, as these cases often end up in the public defender’s court, and then law enforcement is a key contributor. A lot of the cases that we have, that we provide services for are seen in lieu of charges, so law enforcement regularly attends that meeting if they are the person responsible for the case. Schools sometimes are involved in that meeting as well as they often are the referral source for some of these cases and may be the only kind of requiring agency for a family to engage in treatment. We have several of our schools and school districts who have seen real value in this treatment in lieu of disciplinary action in the school, and so they have told parents in lieu of suspension or expulsion, we're asking that you be involved in this treatment program and we will make necessary steps for your child to still receive the schooling that's necessary. Sometimes they've even been such a huge support in if a child is learning self-control strategies and they develop a cue word or a cue signal to help the child recognize that they need to use their self-control strategy. We’ll let the teacher know what that cue is, and then we have consistency across not just their home environment, but also their school environment to help reinforce their use of those skills. The schools have been really supportive of this program, and I think they see a lot of value in their kids receiving support services in lieu of just punitive punishment. So, there are lots of different entities that may not be a part of our regular MDT meeting but come together on a case-by-case basis to support these kids getting the services that they need.

**Jimmy Widdifield, Jr.:**

What I’m hearing is this concept of a community-owned program and what that means in terms of having almost, like a macro-level group of people, that are going to somehow be involved with a family, coming together to make sure that each one of those disciplines are getting their needs met in order to ensure safety for whatever domain they are in. And that they are able to help support the family and other professionals who are working collaboratively to help make sure that the child with problematic sexual behavior is getting what they need, that the other children who are impacted are getting what they need, and all of their caregivers and families. That’s great, Carrie, and to think that you were there at Dee Norton, one of the first to do that in the country.

**Carrie Jenkins:**

I think the other really great thing that having that approach provides for families is a consistent message so families aren't being told by one professional one thing and then by a different professional something else. We're all really communicating a consistent message of: There is hope and healing, here is how we achieve it, and here's how we're going to overcome any obstacles that may exist toward that goal. Having that consistent message across disciplines, I think, is really helpful for families in feeling like they have their feet under them. This can happen and sometimes parents are like, I didn't have a playbook for parenting to begin with, and now I really don't know what to do. They can feel really helpless and hopeless so having that consistent message from all the different community partners that are coordinating with their family helps them feel maybe more grounded. Honestly, it helps them have more buy-in. It takes a lot of work for them to be involved in our treatment. There's a lot of sacrifices that parents have to make to be able to make it work. And so, to have that buy-in from the beginning is really helpful for them to make it to graduation day.

**Jimmy Widdifield, Jr.:**

All of that is happening in a children's advocacy center and it hasn’t burst into flames yet, right? Because I know there's this misconception that CACs are not able to serve these children or even adolescents (even though our focus today is on children) because of their quote “offender” unquote status and that's just not the case. National crediting standards for children's advocacy centers are really clear that children with problematic sexual behaviors can be served by a children's advocacy center, and Dee Norton is certainly proof that it can happen successfully. So that, again, you're helping all children. I’m kind of keeping on this theme. Would you just kind of briefly walk us through the highlights of a typical case? Let's say a child with concerning or other alleged problematic sexual behavior has been referred to the child advocacy center. What's the typical process? We want other people to understand what are the big things that are being done there at the CAC with the MDT in order to best help this family.

**Julia Grimm:**

Sure, I can take this one. And, Carrie, feel free to jump in with anything I forget, other half of my brain, since we're focusing today primarily on school-aged children. If we receive a referral for school-aged child who there are concerns that they have engaged in or initiated some sort of problematic sexual behavior, our first step for that family is, of course, doing a really thorough intake and gathering information from the family, from any involved partners, from the referral source. Sometimes law enforcement is involved with our school-aged kids, sometimes they aren't. For our school-aged kiddos we start with usually a referral for forensic interview, and we do that because we know that frequently poly-victimization is the norm and it's not the exception. If there's concern for some sort of problematic sexual behavior having happened in the home, we know that there may be some concern for other types of maltreatment. Whether it's physical abuse, exposure to domestic violence, neglect, exposure to parental substance abuse, we want to do a thorough assessment and screening for any of those factors that may have contributed to the child's problematic sexual behavior. We would provide a forensic interview for both the initiating child and the impacted child in an effort to try to gather a clear picture of what happened, what is the concern and as many details about that concern as possible. And from there, we would engage our multidisciplinary team, any investigators who are involved in that process, and the referral source and think through what is the next best step. Usually that's going to be a PSB assessment, which is a thorough, comprehensive mental health assessment using standardized assessment instruments, and we use a broad spectrum mental health instrument, a trauma-specific instrument, as well as some instruments related to problematic sexual behaviors. Following that assessment, we again reconvene with a multidisciplinary team, and we'll make a recommendation for that child and/or family. Again, it's a little bit dependent on whether we're talking about an intrafamilial case of problematic sexual behavior where both the initiating child and the impacted child are within the same family where they’re siblings or if it's extended family or if we're dealing with a situation of neighbors. Sometimes the pathway might look a little bit different and the recommendations might look a little bit different, but that's usually our sort of standard pathway for children, where there's a concern for PSB making it into our PSB-CBT program.

**Carrie Jenkins:**

And just to add to that, the forensic interview, like Julia said, for the initiating child is really going to focus on any potential victimization for themselves. We're not going to be talking through any of the circumstances of the problematic sexual behavior in that appointment. That is saved for the therapeutic assessment. That's really just to ensure that we're not asking questions of the child that might inadvertently get them in trouble. We would ask the victim child or the impacted child about the PSB and in their appointment or forensic interview, but we wouldn't be asking those same questions of an initiating child.

**Julia Grimm:**

That's a really important distinction, Carrie, thank you for adding that.

**Jimmy Widdifield, Jr.:**

Thank God I’ve got the other half of Julia’s brain with us today. I mean that's what we're seeing in action right here. It is a really good point, because forensic interviews are designed to collect evidence when abuse or neglect or crime has been committed against a child and keeping that developmentally sensitive approach to when this is child-initiated harm or maltreatment is not meant to be self-incriminating. I totally agree. Julia, I hear you. You're sharing a lot there about the kind of pre-work that's done with these cases, in some ways not being very different from a typical case that gets referred to an MDT or CAC where there's an adult who has been alleged to cause harm against a child. But what I did hear you say, though, in this kind of pre-work before it gets to the MDT is really keeping the focus on, this is a child. We are making sure that we are approaching this from that perspective of, this is a kid who has allegedly initiated harm, and so we need to keep that focus there. So, when the MDT does come together, we can make sure we're talking about a child who needs our help, and this is all the information we have coming into this and now, how do we make informed decisions going forward. So, again you're both giving me these great segues into where I want to go next. We know that Dee Norton has a lot of programs available for children. Tell us a little bit about what therapeutic options you have for children with problematic sexual behavior, the other children impacted, and their families.

**Carrie Jenkins:**

I can take this one. We're fortunate to have a lot available to us. We had a leadership team, who is really dedicated to ensuring that the clients we serve have access to evidence-based treatments. So, they've done a lot of work to get grants and various other funding streams to bring a lot of evidence-based treatments to our community. We also are fortunate to live in a state where Project Best is a statewide initiative for bringing evidence-based treatments to communities, and we have a partnership with the medical University of South Carolina to bring various evidence-based treatments to our community. With that partnership we've been beneficiary of having a lot of therapists trained in various evidence-based treatments. For initiating children, we have been consistently running for 11 years an adolescent and school-aged treatment program PSB-CBT, our Problematic Sexual Behaviors Cognitive Behavior Therapy, which is the evidence-based treatment for problematic sexual behaviors. We also provide that on a family basis, depending on client need, various times. We, for whatever reason, have not had enough referrals for preschool to ever launch a preschool group. Actually, we did—probably 11 years ago—have one client and never expanded beyond that. We really value the partnership we have with Dorchester Children's Advocacy Center because they consistently have had a preschool program running and so a lot of our referrals get routed to them for preschool unless we do family based for that. For other treatments in terms of the impacted child and/or sometimes the initiating child, we also provide Parent Child Interaction Therapy, Trauma-Focused Cognitive Behavioral Therapy, and we have therapists who are trained in TF-CBT or Trauma-Focused Cognitive Behavioral Therapy augmented with PSB-CBT. It's the alphabet soup Jimmy referenced earlier. We also, for adolescents with sexual behavior or high-risk behaviors in general, have risk reduction through family therapy, so some youths who have risky sexual behaviors have been routed to that treatment program. I’m sure I’m forgetting something, Julia, perhaps other letters that we have?

**Julia Grimm:**

I think you covered everything. Sometimes if we have a child or children where there was some concern, but it doesn't quite rise to the level of needing a formal evidence-based intervention, we have some prevention programming here, where we teach good thorough body safety psycho-education and abuse prevention skills. So sometimes we’ll route children and families to that if there's some concern for what we call sometimes “concerning sexual behavior,” but it's not quite all the way to the level of problematic and needing a full course of evidence-based intervention.

**Jimmy Widdifield, Jr.:**

I hear a lot of about the services that the CAC has created, programs to address and to meet the needs of your community, and really well done. I’m hearing services not only for the child who initiated PSB, but also for the other children, so victim services, but also family services, prevention services, and I know Dee Norton provides a lot of other things as well, so there's quite an array of options there to help these families. We know that not all CACs have that kind of array of services in their community or at their CAC, and lots of different reasons for that, but I think what I’m certainly hearing here is that it's possible, and it goes back to that passion and commitment that we were talking about at the very beginning, not to say that other CAC's don't have that. But I think there's a way to work that passion and commitment. I’m going to ask you each to share with me what you think one primary barrier has been, in your opinion, there at Dee Norton and getting services to families. And what's been just one of those successes that you think, this is really why I do this work, right here is the success that I can think back to after having a difficult day and that's what's going to give me that energy to move forward. Maybe we'll start with Julia and then go to Carrie.

**Julia Grimm:**

I think the primary barrier that comes to my mind, is really overcoming stigma associated with having a child who has engaged in a problematic sexual behavior. And I think there are still a lot of people and a lot of places who are conceptualizing children and youth with PSB like many adult offenders when nothing could be further from the truth. These behaviors tend to be curiosity based, they tend to be imitative, they tend to be impulsive, they tend to happen between children who know each other, who have existing relationships. I think just overcoming this fear-based stigma and judgment that exists among other community partners, other providers and even our own staff and has been a barrier that we've worked really hard to overcome and continue to work on overcoming. We do that by offering trainings, psycho-education and sharing success stories of the healing that can happen when kids get the treatment that they need, which leads me to the successes that keep me going. I’m thinking specifically about we've had several families over the years with intrafamilial sibling problematic sexual behavior. When we have been able to keep those families in-house at the CAC and have one of our TF-CBT-trained providers doing TF-CBT with the impacted sibling and having the initiated sibling engaging in PSB-CBT with our PSB-CBT team. And those providers regularly communicating and approaching this family with the same framework and through the same trauma-informed and developmentally appropriate lens. We have seen some really incredible healing and reunification and forward movement happen for those families. And the other side of that coin is circling back to what we were talking about. We were mentioning the MDT also worked with families where the impacted child was being seen by a community provider. The initiating child was being seen by our team and that community provider didn't have the knowledge base that we have instilled in our staff. So that family was getting a very mixed message about whether or not or, to what degree, it was safe for their children to ever be in the same home together. And, and so I think that also ties into that barrier of stigma and that success that we can achieve when we overcome that stigma and everyone is working under the same understanding of how these behaviors develop. These are, first and foremost, children with a behavior problem that is sexual but a behavior problem, nonetheless, that can be receptive to the same kinds of behavioral interventions we use for other problematic behaviors. So, everything just sort of gets tied up in one neat little package for me when we're talking about barriers and successes.

**Jimmy Widdifield, Jr.:**

Stigma is just a huge part, isn't it, and when you can see that being driven down, right? When you can see stigma being reduced, what a beautiful day that is. Carrie, what about you?

**Carrie Jenkins:**

I think the barrier that came to mind, for me, is really interconnected in the stigma piece. It's the turnover that happens. This field can burn people up, and so we have sometimes high rates of turnover in our staff and community partners. We are kind of continuously finding ourselves in need of reminding or educating or informing new members of the team about this population, giving them accurate information, as opposed to whatever mainstream media says about this population of people. And again, that ties exactly back to stigma and the fact that what may seem ubiquitous as the understanding about these kids is not at all based in the research. So having to do some re-education about what seems logical is not correct necessarily. I know that early in this project we saw kind of a dip in referrals after we had had the program running for about three years and we saw this real dip in referrals and I was like, “What's going on?” So, I reached out to some of the senior people connected to the MDT partners and was like, “Hey, we've noticed this, radio silence, what's happening?” And they're like, “Oh, we have whole new staff.” And in my head, we had beaten them over the head with information for three years now non-stop, and so I didn't see the value of continuous outreach until I had those conversations. I was like, “Oh well, these people don't know anything that we've said over the last three years,” and so started developing a plan for continuous outreach so that we're always catching the new person up and helping them feel in the loop with the information. I think to that point, in addition to Julia’s success story which I, keeps me going, I think the wins that we make with our community partners are energizing for me. Unfortunately, this treatment is not available as widely in South Carolina as we would like it to be, and so we sometimes do get referrals for families outside of our kind of catchment area. This was one of those situations where the prosecutor, who's charged with community safety, is not a prosecutor we work with regularly. We had the opportunity to provide some good education about how this population can be served in the community. We were able to make some arrangements, so this child didn't have to be detained when that wasn't therapeutically necessary, didn't have to get a treatment that may or may not be effective, which is all they would have access to in the detention center or in a group home if that was the route they chose to go. Instead, this child was able to remain in the community and be served with the treatment we know is going to be effective, or more effective than displacement when that wasn't, again, clinically necessary. So, I think those are also real big wins that keep me going.

**Jimmy Widdifield, Jr.:**

Oh well, I’m glad you both continue to have the gas to keep going forward. So, I had another question that I was going to ask, but you've already answered it so tell me if I get this right or not. I really wanted to hear a little bit more about, kind of how you see cases being handled differently now versus 11 years ago. But I’ve heard from you both so much about how you're reducing stigma, you're engaging partners and how that's leading to more for families. And I’m leaving “more” generally vague there because it covers so much and working to build a network across the state of South Carolina—I heard you mentioned Project Best earlier in your partnership with the University of South Carolina. And so, I say that the difference now is that cases are being seen, the consistent services and approaches from across all disciplines at the MDT are happening for families, and you're working on increasing capacity within your state in your communities while reducing that stigma and that's a huge thing. Did I get that right?

**Carrie Jenkins:**

You did. I realized this is a podcast and I was nodding my head, but that's not visible!

**Julia Grimm:**

Carrie and I are just sitting over here looking like bobble heads, and you can’t see our heads nodding.

**Jimmy Widdifield, Jr.:**

So, in our last couple minutes that we have together—and you've both been so super generous with your time and just your perspective and thoughts. Now here's the magic question, right, and this is what I’m most excited about. What are your wishes or dreams for the future of the field of children with problematic sexual behavior, where do you see the field going or where do you want to see the field go to help these kids, all the children impacted and their families? We’ll start with Carrie and go to Julia.

**Carrie Jenkins:**

I have so many wishes. I think one global kind of desire that I have is that, regardless of geographic area or, if you won the geography lottery, that you would have access to services and evidence-based services, services that we know are going to be effective. So, I think, that would be huge, is just really spreading access to evidence-based treatments. I think the other desire that I have with the field is to have a better sense of what about adolescent treatment is the key to the recipe. What about it is makes it effective? There's two really great treatments that are the most evidence supported in terms of multi-systemic therapy and PSB-CBT for adolescents. To me they have a lot more similarities than differences and this is someone who is not trained in MST (multi-systemic therapy) treatment, so I may be speaking out of turn, but I'd like to know, from real research around what about them makes those treatments work.

**Jimmy Widdifield, Jr.:**

I want to make a quick distinction. PSB-CBT for adolescents does not have any published research on advocacy. It's based on program evaluation data here in Oklahoma. But, like many other treatments, when we look at that program evaluation data, we're looking at very high success rates of 97%, 98%. What I hear from you, Carrie, is really where you want to see the field go is being able to increase capacity and access to evidence-based treatments for these kids, but also if we already know what works to help children not reengage in problematic sexual behavior, how do we extend that to when they get older into adolescence? The goal here is that children get older, and they grow up and so, how do we help families throughout the continuum of childhood, so that we are doing the best we can at building strong children and not necessarily coming back to repair them? Julia, what are you your wishes and dreams for the field?

**Julia Grimm:**

I agree with Carrie in terms of access to these interventions. I think a lot about where I grew up. I grew up in a very, very small rural town in north central Indiana. I sometimes shudder to think about what those kids are getting, if they're getting anything, and I think about, how amazing would it be if every kid who needed it had access to an intervention that not only can reduce the likelihood of future problematic sexual behavior but also improve their decision making overall, improve their social emotional skills and functioning, and enhance family functioning, which are all things that our interventions do. And it's a very holistic and developmentally appropriate approach. I would love to see every kid who needs it, regardless of where they are geographically, have access to that. The other thing that I wish for the field is, and I think it ties into access to intervention, is for fewer kids to be removed from their homes, to be removed from their communities, their support systems, their networks. For fewer kids to experience the severing of those critical, social, emotional, familial connections and further the greater recognition that these kids can be and are treated safely in the least restrictive environment in the community. I think that's my wish is for kids to be able to stay connected to their communities and have equitable access to needed intervention.

**Carrie Jenkins:**

And I think to that point, Julia, having policy decisions that are made and grounded in science, as opposed to emotion. I mean we know that the sentencing related to these cases is so often connected to an emotional reaction to the behaviors and the fact that they create an emotional experience in those of us who care about them and oftentimes that looks punitive or that looks overly punishment-driven as opposed to rehabilitation-driven. So that to me goes hand in hand with your hope.

**Jimmy Widdifield, Jr.:**

And what a wonderful wish, right, is that you just want families to be strong, you want children to be strong and you want to keep families, to get the right services, and not everything needs the big sledgehammer when you can use, you know, something else to accomplish the same goal. Carrie, just to echo again, it's about what we know. While the research is not massive in this field as maybe compared to helping children who've experienced abuse and neglect or other crimes, there is good research, there is quality research to help us know what works and how to approach these cases, regardless of our discipline, regardless of our role. Well, I'll just share really quick that my wishes and goals for this podcast has really been fulfilled, and I really just appreciate this great conversation about you and your thoughts and what you're doing there at Dee Norton Child Advocacy Center in Charleston, South Carolina. Your involvement with the National Center on Sexual Behavior of Youth, I know that you've got some other involvement like with National Children's Alliance and a work group there. Carrie and I recently did some training together for the state of South Carolina in partnership with the Southern Regional Children's Advocacy Center and the South Carolina Network of Children's Advocacy Center. I think it really gets to, that there are people out there who want to help all children and, in the end, to be clear too, I mean our focus today has been on children who have initiated problematic sexual behavior. But I’ve heard a lot from both of you, about that it's not just about helping that child, but it's helping the other children that they have had the PSB with, their parents and their families and their communities. So it's a comprehensive holistic approach to helping our kids, all of our kids. Well, that's it, I mean it takes a podcast to get us to that simple statement, that's it. Thank you both for your time and thanks to Southern Regional Children's Advocacy Center for hosting and doing the behind the scenes work of it all, so wishing you both a great week. And, knowing that you'll continue to do great work, not only for these kids and for all children. But no matter what you do, the world's a better place because of you both, thanks.