Comparison of children's advocacy center responses to harmful sexual behavior among siblings: An international perspective[☆]

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ABSTRACT

Background: Harmful sexual behavior (HSB) is sexual behavior exhibited by children and adolescents that is developmentally inappropriate and/or harmful or abusive towards themselves or others. Victims of children with HSB are commonly siblings. Multiple professionals may be involved in cases of youth HSB involving siblings, which places Children's Advocacy Centers (CACs) in a key position to directly address intrafamilial HSB. Approximately 25% of all cases seen at CACs in the U.S. are youth-initiated HSB. However, no known research has examined how CAC professionals approach decision-making and response to intrafamilial and sibling HSB, particularly across regions and cultures.
Objectives: To examine the perspectives of professionals from three separate CACs in Israel, eastern U.S., and southwestern U.S. regarding their decision-making and response process for sibling HSB.
Participants and setting: Thirty-seven multidisciplinary team members from the three CACs, including representatives from child welfare, law enforcement, family advocacy, mental health, and the court system, among others, participated in the study.
Methods: Participants completed focus groups that asked them to discuss how their system would respond to a vignette case. Dedoose was used for thematic analysis.
Results: Using qualitative thematic analysis, results indicate all sites perceived sibling HSB as a family crisis, and they prioritized establishing safety and providing therapeutic interventions. Differences across sites were on how to establish safety and when to use legal actions.
Conclusions: The study draws attention to the influences that formal policy and community contexts have on CAC decision-making, particularly around the availability of evidence-based treatments and caregiver engagement.

Harmful sexual behavior (HSB) is sexual behavior exhibited by children and adolescents that is developmentally inappropriate and/or harmful or abusive towards their self or others (Hackett et al., 2016). Children and adolescents of all ages engage in HSB, but research suggests the peak age for the behavior is between 12 and 14 years old (Finkelhor et al., 2009). It is estimated that over one-third of known child sexual abuse cases in the United States (U.S.) and United Kingdom (U.K.) are committed by other youth (Finkelhor

et al., 2009; Hackett et al., 2016). Victims of youth with HSB are commonly siblings of the youth, as well as other close family members and peers (Allardyce & Yates, 2013; Caffaro, 2016; Finkelhor et al., 2009; Tener, Newman, et al., 2020; Tener, Tarshish, & Turgeman, 2020). A growing body of research on sibling sexual abuse has suggested that such intrafamilial HSB occurs more often than caregiver-perpetrated child sexual abuse (U.S. Department of Health and Human Services, 2016; Kiselica & Morrill-Richards, 2007; Morrill, 2014).[1]

Multiple professionals may be involved in cases of HSB of youth, including law enforcement, child welfare, child protective services, behavioral health, medicine, schools and child advocacy. Unfortunately, these professionals commonly lack clear policy regarding addressing HSB of youth, especially between siblings, which leaves professionals to address these complex cases without evidence-based guidance (Kelley et al., 2019). Unclear policy results in inconsistent and arbitrary responses to HSB in multiple countries across the world (Kelley et al., 2019; Masson & Hackett, 2004; Removed for review). Considering their intervention and response work for child maltreatment, as well as their efforts to coordinate multiple disciplines, Children's Advocacy Centers (CAC) across the world have increasingly responded to and addressed HSB of youth.

1.1. Children's advocacy centers

Created in the U.S. in the mid-1980s, CACs provide coordinated responses to child maltreatment by integrating social, legal, medical, and mental health services for the investigation, response, and intervention of child abuse and neglect (NCA, 2016). Originally focused exclusively on child sexual abuse, many CACs have expanded their purview to investigate and respond to multiple forms of child maltreatment. Today, there are over 950 CACs in 34 countries worldwide (National CAC, 2021). As part of their work, CACs streamline case management, minimize investigative interviews, and protect the well-being of children and their families by centralizing services in one child-friendly location, thereby reducing the emotional impact of disclosure and improving rates of prosecution for child maltreatment (Miller & Rubin, 2009; Rasmusson, 2011; Wolfteich & Loggins, 2007). Notably, prior to the formation of CACs, investigations into child abuse were not well organized across systems, often leading to negative consequences like lack of prosecution and delays in investigation (Jones et al., 2007). By promoting communication across multiple agencies, CACs allow for a coordinated, systemic response for both the child victim and all non-offending family members (Jones et al., 2007). This multidisciplinary team (MDT) of professionals is able to make collaborative decisions with the family regarding legal proceedings and case management, as well as facilitate access to needed mental health services (NCA, 2018). Within the U.S., the CAC model has been recognized by the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention as an evidence-supported program for responding to child sexual and physical abuse (NCA, 2016).

Even though they are based on an MDT model to address child maltreatment, CACs often differ from one another in organizational structure, location, and community involvement (see Walsh et al., 2003 for in depth discussion). For instance, CACs may be independent non-profit organizations, housed in a hospital, or a part of a larger government organization, such as a prosecutor's office. Regardless of their organizational construct, most CACs are not state regulated but rather follow the accreditation standards developed by the National Children's Alliance (NCA), the national membership organization for CACs. The standards are evidence-based and updated every five years to reflect the latest evidence and practice (NCA, 2020). Accredited CACs must meet 10 overall standards, including functioning MDTs, performance of forensic interviews, providing appropriate victim advocacy services, and referrals for specialized medical and mental health services. The standards value diversity in CACs, including organizational structure, staffing patterns, and socio-economic factors in communities, making them adaptable to different communities.

Based upon accreditation status and community resources available, there is some variance in the provision of services between CACs, but all CACs are designed to provide evidence-based forensic interviews, victim advocacy, and MDT meetings. Some CACs provide additional services, including offering court-specific supports, on-site mental health services or medical evaluations, and services for sexual abuse as well as other forms of child maltreatment (e.g., physical abuse, witnessing violence). Each CACs' policies and procedures are influenced by the legal, organizational, and cultural aspects of their regions.

With regard to intrafamilial HSB, NCA has prioritized the examination of best practices to address HSB of children and adolescents, notably determining that approximately 25% of all cases seen at CACs in the U.S. are youth-initiated HSB (NCA, March 2021). The high prevalence of cases of HSB seen within the CAC and the history of fragmented responses by community professionals led NCA to provide concentrated efforts to improve strategies for CACs to address HSB of youth. Resources (e.g., video training series, fact sheets, best practice guidelines, webinars) are freely available to CACs in the U.S. Currently, these resources are unique, with no known similar resource available for CACs outside of the U.S.

1.2. Current study

Recognition of and concentrated efforts to address youth HSB has increased substantially by CACs over the previous decade. Despite the high rates of intrafamilial HSB that present to CACs and efforts to improve responses to HSB of children and adolescents, it remains unclear how multidisciplinary responses occur in the field. To date, no known research has examined how CAC professionals approach decision-making and response to intrafamilial and sibling HSB, particularly across regions and cultures. As such, the present

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[1] Considerable heterogeneity is found in characteristics, causal factors, victimization history, co-occurring conditions, and social-ecological features of HSB among child and sibling sexual abuse (see Chaffin et al., 2008; Caffaro & Conn-Caffaro, 2014; Hackett et al., 2016; Silovsky, 2009 for further information).

study examines the perspectives of professionals working at three separate CACs in Israel (ICAC), eastern U.S. (EUSCAC), and southwestern U.S. (SWUSCAC) regarding their decision-making and response process for sibling HSB.

To do so, we completed focus groups with each of the three CACs' MDTs to gain a greater understanding regarding multidisciplinary responses to HSB of children and adolescents. Using a hypothetical vignette of HSB, the focus group members were asked about their perceived process for addressing sibling HSB, as well as to discern the contextual environmental, familial, and case factors that may inform each teams' response. Below, we discuss the methods and qualitative analytic process used to analyze the focus group data, as well as the salient themes that emerged from each CAC regarding their response to HSB. We highlight overlap and variety in their discussions and provide recommendations for next steps.

2. Design and method

2.1. Sample

Three separate CACs in Israel (ICAC), eastern U.S. (EUSCAC), and southwestern U.S. (SWUSCAC) were included in the study, as each had experience in managing and addressing HSB in youth. Notably, the scope and availability of CACs across Israel and the U.S. varies widely; there are seven total CACs in Israel, whereas the U.S. has over 900 CACs spread across all 50 states. We found that all three CACs varied widely in their local regulations, practices, and cultures. Therefore, although both US sites were accredited and offered forensic interviews and MDT services, we felt there were enough differences in the responses to warrant not combining them into a single representative 'U.S.' site.

2.1.1. ICAC
The ICAC was established nearly two decades ago. Based on the American model of CACs, the ICAC is located in a large urban area and is supervised by the Israel Social Services Ministry in partnership with the Ministry of Homeland Security, Ministry of Justice, and the Ministry of Health. The ICAC is funded and supervised by the government but operated by a non-profit organization. Within the country of Israel, the age of legal responsibility is 12 years old; as such, children who are 11 and under are not arrested or charged. In addition, the Israeli government allows for an Exemption Committee (Tarshish & Tener, 2020), which allows exemption from legal actions for specific cases. Thus, the team can request a therapeutic response, rather than a legal one, for children over 12 if all family members agree to participate in services. Further, if the family stops attending or otherwise stops cooperating, then the case automatically reverts to the legal process.

2.1.2. EUSCAC
The EUSCAC is a free-standing non-profit organization located in a suburban setting of a Northeastern U.S. city and provides services to 600 children each year. Their MDT contains a large number of community partners, with 50 independent police departments, multiple child welfare agency teams, and four or more prosecutors, any combination of whom may be involved in cases of children with HSB. None of these partners is housed on-site. Due to this wide variety of community partners, a unique MDT is formed in response to each case of HSB. Notably, the EUSCAC is limited in the therapeutic response it can provide to children with HSB. There are no mental health providers in the area able to treat siblings with HSB, unless the youth is over 10 years of age, has charges filed, and is found "delinquent" in the juvenile justice system.

2.1.3. SWUSCAC
The SWUSCAC is similarly a free-standing, non-profit located in a large urban area of a southwestern U.S. state. They provide services to over 1500 children annually. Housed within the SWUSCAC are multidisciplinary partners, including special victims' detectives from the local jurisdictions, CAC-specific child welfare caseworkers, medical providers, and others. The SWUSCAC also has a close collaborative partnership with community mental health providers that deliver evidence-based mental health services for children with HSB. Children as young as seven years of age can be adjudicated legally; however, adjudication is typically reserved for youth 12 years and older in practice.

2.2. Materials

Focus groups were conducted using a semi-structured case example and interview. Interview began with a hypothetical case example in which a 14-year-old brother touched the private parts of his 6-year-old sister and then touched his own private parts; the sister subsequently disclosed that it was a game her brother invented, and it was the first time they played it. Specific questions concerning the scenario were asked, such as, "Tell me your first steps in managing this case," "What else would you want to know [regarding this case]?" and "How would the MDT manage this case?" The initial discussion was followed by questions in which specific characteristics of the case example were changed, such as the ages of the children, their genders, their relationship, and the type of sexual behavior displayed, in order to better understand if and how the MDT response would vary based on these changing details. For example, the focus group leader would ask how the team's response might change if the children were 11 and 9 years old, instead of 14 and 6, or if they were two boys or two girls versus a mixed-gender sibling set. The group at the ICAC was conducted in Hebrew and the three U.S. focus groups in English.

2.3. Procedures

Data collection was completed with four focus groups, one each at ICAC and SWUSCAC and two in EUSCAC, which took place between December 2018 and June 2019. The EUSCAC completed two separate focus groups in order to account for the large number of MDT members who could be involved in the investigation of SSA allegations. Focus groups are a traditional and supported method for generating research data concerning meanings, perceptions, beliefs, and collective views (Morgan, 1998). Focus groups may allow for a more relaxed setting for participants to express their thoughts and beliefs, and their sense of belonging can create opportunity for discussions (for review see Onwuegbuzie et al., 2009).

The authors, in coordination with each MDT lead, sent an e-mail invitation to the team members who work on SSA cases at the three centers and asked for voluntary interest in participation. Those team members who expressed interest were invited to attend the focus groups. Each group met for approximately 1.5 h. For each team, one or two of the authors introduced the study to the CAC and subsequently directed the discussion.

The groups at the ICAC and SWUSCAC were conducted in person. Alternatively, the groups at the EUSCAC were both conducted via Skype and were led by the Israeli researcher. Each focus group session was attended by 7 to 13 participants, all of whom were MDT and staff members of the CACs. The ICAC focus group had seven participants, which included two social workers, a child investigator, a law enforcement officer, a doctor, a prosecutor, and a case coordinator. These same professionals investigate each SSA case at the ICAC. The SWUSCAC group focus group was comprised of their standard MDT team members, with 13 attendees, including the MDT coordinator, two law enforcement professionals, two mental health providers, one registered nurse, one pediatric clinic coordinator, one physician, four hospital social workers, and two state child protective services workers. The first EUSCAC focus group of 11 individuals included one mental health professional, two law enforcement professionals, one child welfare caseworker, two CAC administrative staff, three forensic interviewers, and two family advocates; the second with six members included a forensic interviewer, family advocate, child welfare caseworker, prosecutor, law enforcement professional, and an administrative CAC staff member. Overall, a total of 37 individuals participated in the focus groups across the three CACs.

The focus groups were directed by the authors, and open-ended questions enabled the group members to talk freely about their experiences and elaborate on the topics that were meaningful to them. Each focus group at the ICAC was transcribed by a research assistant or a secretary who was present during the session and then translated into English. In the EUSCAC, two CAC staff members transcribed during the sessions, and these notes were combined and forwarded to the second author. Finally, at the SWUSCAC, the focus group was recorded on digital recorders. The recording was then transcribed by research staff and reviewed by focus group leaders for accuracy. To maintain the privacy of the group participants, no details are given about the participants themselves beyond their professions.

2.4. Ethics

Approval from all respective Institutional Review Boards was obtained prior to administration of research protocol. Before starting the focus group, it was emphasized that participation was voluntary, and all participants freely signed participation consent forms.

2.5. Data analysis

We used a qualitative thematic analysis approach (Braun & Clarke, 2006) in order to analyze the transcripts from focus groups in the three sites. Prior to formal analysis, the responses from both EUSCAC focus groups were collapsed into one dataset so that all three CACs had equal representation in the forthcoming results. Thematic analysis of the results included several interrelated stages. First, focus group transcripts were read several times so the authors could become familiar with the data and identify initial ideas. Each interview transcript was then entered into the computer program Dedoose (2018) Version 8.0.35. Open coding was performed to elicit initial categories; the focus group transcriptions were broken into small segments of text, representing discrete "units of meaning," and each unit was labeled according to its content.

In the next stage, the codes were grouped together by the authors. As the authors read the cases, some of the themes were removed or changed, while additional codes and categories were added. For example, several codes were defined as "professional responses: with parents," whereas others were defined as "professional responses: safety and placement" or "response: legal" as opposed to "response: therapeutic." In the third stage, the themes and subthemes were reviewed and classified by their dimensions and properties (Corbin & Strauss, 2008).

Finally, in the final stage, themes were refined, named, and interrelationships between them were suggested (Braun & Clarke, 2006). For example, the previously identified themes of responses were further classified into "central elements in professional responses in cases of siblings classified with HSB: the centrality of safety and interactions between therapeutic and legal responses." At this stage, the authors referred back to the transcripts to retrieve additional information as required to develop the categories (Maykut & Morehouse, 1994). Once all stages of the analysis were completed, comparisons were made across the three CACs to identify themes reflecting commonalities and differences in experiences and perceptions.

These analyses were performed by the authors. Selected excerpts from the source materials were discussed throughout the process in several peer-debriefing sessions with all the authors. The audit trail included detailed documentation of all analysis stages, with raw excerpts attached to all interpretations (Creswell & Miller, 2000; Lincoln & Guba, 1985). The entire analysis process was accompanied by reflexive writing by the authors on their ideas, perceptions, thoughts and feelings as they evolved (Cope, 2014; Nowell et al., 2017).

3. Results

Overall, focus groups across the three sites resulted in several major themes regarding how to address youth with HSB. Our results and review of the themes led us to determine it would be best to present the results from each of the three sites separately, rather than collapsing the two U.S. sites, as there was variability across the sites in their responses regarding the central themes.

3.1. HSB is a complex family problem

All three CAC groups defined and framed the case of sibling HSB first as "a family crisis," as illustrated in one EUSCAC participant's words:

> The things that happen afterwards are sometimes more traumatic than the abuse itself. And this is in most cases where the family breaks up … the victim child can be blamed where sometimes it feels like what happens afterwards sometimes affects the child more than the actual abuse itself. So, it's hard to say, so that's why I hate this case.
>
> (EUSCAC participant 1)

Thus, when the professionals at the three CACs intervene in these cases, they view them as involving the entire family, seeing the entire family as the focus of intervention not just the siblings involved in the sexual behaviors. The family is a key part of the therapeutic process, as will be described below. Further, all three CAC's participants agreed on how complex and difficulty-to-manage these cases are. This complexity can cause a strong emotional response from professionals, as further emphasized by a EUSCAC participant:

> My experience has been everyone feels like… that… an "uh-oh" feeling in those cases, like they don't like, like… the whole team agrees that they hate it, right? And I think the whole team understands that this kid needs safety. I don't think the team always disagrees on how to get that, right? Like some people may say, "We need to remove that 14-year-old," or "No; we need to remove that victim child, because parents aren't being supportive," and we think that some other people may say, "That's retraumatizing the victim; why are you taking the victim out?" So I think some of the… They all hate this case; they all know something needs to happen; they all agree on that. Sometimes the logistics of it, that's where it gets a little sticky on what should happen. (*Sympathy calls from other group members*).
>
> (EUSCAC participant 1)

Further analysis of the three focus groups yielded two main themes: (a) the centrality of safety within the response and (b) the interaction between legal and therapeutic responses. One should notice that during the focus groups, participants relayed responses both to the case presented and to their perceptions and experiences in siblings involved in HSB in general.

3.2. The centrality of safety

All three focus groups members put safety plans at the center of the initial response to ensure that no further abuse occurred to the victim child, as explained by one of the participants:

> Our response would be [to] visit with these parents, we would establish whether or not they had developed their own safety plan, what actions they had taken, if they believed their daughter. And we would have either assist[ed] the family in coming up with a safety plan or, if they were hesitant to that then we would maybe put more intervention in place and make things a little more official. But that would kind of depend on what the family was telling us. I think that would be our first step.
>
> (SWUSCAC participant 9)

The great complexity inherent in cases of siblings with HSB when creating a safety plan and the difficulties it creates for families were themes across all three locations. At the same time, the three groups differed in relation to the necessity of change in residential placements to achieve safety. Professionals in EUSCAC tended towards separating the children by moving the sibling with HSB or the victim sibling to a placement outside the home, while the SWUSCAC and ICAC's tendency was to examine the possibility of maintaining all children in the home, if it could be done safely. The belief in the need for out-of-home placement but the challenges inherent in implementing the separation was explained by one of the EUSCAC participants:

> Then when the child victim is the one who told someone and then the child actor then leaves the home, the child victim feels then that it was her fault that he's gone and now it's you know … "Should I have said something … Or should I have kept the family together?" And it really pulls the family completely apart. […]
>
> (EUSCAC participant 2)

> Like some people may say, "We need to remove that 14-year-old," or "No; we need to remove that victim child, because parents aren't being supportive," and we think that some other people may say, "That's retraumatizing the victim; why are you taking the victim out?" So, I think some of the… they all hate this case; they all know something needs to happen; they all agree on that. Sometimes the logistics of it, that's where it gets a little sticky on what should happen.
>
> (EUSCAC participant 1)

Notably, although the EUSCAC professional describes the problems inherent in the removal of each of the children from the home, they still assume that one of the children must be removed. This is further emphasized in the next quote:

> Think it also sometimes depends on how many other kids are in the home. My recent case there was three young kids… there was four total kids, three of them younger than the actor. And then so the actor was removed from all three of the young kids.
>
> (EUSCAC participant 2)

In SWUSCAC and ICAC groups, opinions were divided concerning HSB cases. Some professionals thought it was appropriate for one of the siblings to be removed, but others thought that all children could remain with family if appropriate safety solutions could be found. This is further described by one of the ICAC members:

> Usually when it is a therapeutic procedure, it is the [child] welfare responsibility and then you have to find a solution together with the family. It's not always easy for me to say, 'get the kid out.' It's not always in the interest of the matter. We'll find Grandma [but] she really has no ability. In that case, I would not require a stay away from home, but first and foremost, a home-safety plan. Do not leave him alone. Do not close doors. Parents cannot leave. Do not leave him with other siblings.
>
> (ICAC participant 1)

Both the SWUSCAC and ICAC groups emphasized the parents' central place in creating a safety plan within the home environment. Such decision-making, as described by participants, is strongly dependent on the ability of the parents to protect the resources they have available, and how likely they are to continue engaging with service providers. For example:

> What is the, you know, what is the ability of the parents to protect? What resources do they have to put in place? How much would they like to continue to engage with services providers? Are they getting this kid help? There's so many elements [to consider].
>
> (SWUSCAC participant 9)

Notably, the safety plan requires attention to emotional safety of the child victim in addition to physical safety. Creating a safety plan within the house involves mutual effort from professionals and families to find solutions that can be implemented, as described by a SWUSCAC member:

> You know, if they've got friends and family, let's utilize friends and family. Um, if mom and dad are comfortable staying elsewhere, if they have the means to stay elsewhere. One parent goes with one kid, one parent goes with another one. However, it needs to be worked out. We try to do it in a way that is easy on the family. You know, we don't want to break them financially or anything like that, but at the same time we need to make sure that both of these kids, and the other children that are in the home, are protected.
>
> (SWUSCAC participant 10)

3.3. Interaction between therapeutic and legal responses

Professional responses to HSB of youth often involve legal and therapeutic aspects. Three different approaches were described by the three CAC groups. The first approach outlined about legal proceedings including investigation, trial, and judicial outcome for the child with HSB as an integral part of the process. This approach was characterized by the EUSCAC team, where CAC procedures require that all investigation activities are complete prior to initiating therapeutic services; thus, children over the age of 10 with HSB are unable to access therapy before the judicial proceedings are concluded. Further, this group described how legal proceedings may be the only way to access the appropriate treatment for the HSB children:

> That's also a consideration that I'll look at, if we want to charge someone. You know if the case is serious as we're doing it, then obviously, they need some kind of treatment. But a lot of times with Juvenile Court, it's the only way… As much as I hate charging kids with sex offences that can stay on their record the rest of their lives, at the same time… if we don't do that, we can't guarantee that they're going to get the proper treatment.
>
> (EUSCAC participant 3)

In contrast, the ICAC tended to seek to refer these cases to therapeutic channels, avoiding legal responses. In their view, legal actions, although occasionally applied, were often ineffective and even harmful. The Exemption Committee, as noted above, allows for exemption from legal actions and instead uses referral to a therapeutic channel if all family members agree to participate in the therapeutic route. Members of the ICAC described how most of the cases they receive involving siblings with sexual behavior are referred to the Exemption Committee.

> At the next stage, I will make it clear to parents that there is a mandatory duty to report. I will not do things behind their backs if they are the ones who came to us. […] We say gently, "In principle, it's mandatory, but we want to check with you whether we have to contact the police or there are other channels."
>
> (ICAC participant 2)

The ICAC considered several factors before pursuing the Exemption Committee, including how harmful the behavior was, the parents' level of cooperation, and the victim's emotional state.

The third approach was characterized by the group in SWUSCAC. Their general response was that a therapeutic route should be attempted first if the parents are willing and able to protect the child. However, if caregivers do not cooperate, then legal action can be pursued to promote their engagement in treatment and rehabilitation. For example:

> I think some of that goes back to the fact that it's about rehabilitation for them. That even if they're reluctant to admit the information with the juveniles, we're still going to put them in those programs that are gonna help offer them services they need.
>
> (SWUSCAC participant 2)

Note that this third, therapeutic approach also described some EUSCAC team members, and all three groups noted that factors like the severity of the behavior affect the professional response.

3.4. Collaboration among professionals in the CACs

A common theme for all three CACs was the importance of communication and the shared language that was created between team members. Participants felt that using language that creates common understanding for the complexities of the cases of youth with HSB and enhances communication among members of different professions was helpful for investigations.

> I think that's kind of why the MDT process is so critical to any case because without knowing all the different elements and what's going on and the different pieces of what everybody else is doing, you know and the specifics of that family and ways that we're not getting the same information … Every person at the table has different information that they're providing to use to try to help make a decision about how to keep these kids safe.
>
> (SWUSCAC participant 9)

In our participants' experiences, the creation of a common language bridges different views, job priorities, and perceptions that are inherent across the multiple professions represented on an MDT. The joint work enhances communication among these different languages, which in turn provides a mutual foundation and trust for dealing with the complex cases of sexual behavior between siblings who required careful and sensitive work. The importance of interdisciplinary communication was further described by one of the ICAC participants:

> Part of the uniqueness of the CAC is that if you brought this [*siblings with HSB*] up in the police, there is no such discussion [about the exemption committee]… that's what's nice here. At a police station, there is no discussion because there is no social worker sitting in the office near you to tell you to consider other things. At the police station, it will not be. There you have instruction, and you work according to it, and it's done. What is beautiful here is talking about it …
>
> (ICAC participant 4)

All three groups acknowledged the difference between working together with members of the CAC, who were considered safe and trustworthy, compared to working with organizations and professionals outside the core CAC team. Respondents noted that working as a team is a complex procedure in which all professionals have to find common ground and to agree on the best way to deal with complex cases:

> So those who are attended (in the CAC) on the same day sits together. Each one says their opinion, child protection officers, police officers, child forensic interviewer, the doctor, the house mom, and then a discussion begins. And everyone is part of the consultation and has an opinion. And if everyone see eye to eye it can be short. But otherwise there could be conflicts…
>
> (ICAC participant 2)

Yet all three CAC's sites members emphasized the shared values and language they have with each other, while at outside agencies professionals' attitudes were considered variable, unstable, and sometimes harmful to families. When cases were assigned to agencies in other counties without a CAC, there was even more concern:

> I think just whose assigned the case can be the biggest thing too. Like if I knew that these two workers had it [*gestures to workers*], I'd be comfortable, but if I knew that certain workers had it, I'd be like "oh, God bless." You know and it's the same thing with law enforcement. With our unit, we trust them, and we know it's going to be a job well done, but there are other places where like ok…what can we do to help make sure that they do this right?
>
> (SWUSCAC participant 3)

Another participant from SWUSCAC emphasized the potential harmfulness of responses when investigations were conducted by professionals outside the CAC:

> We struggle with [child welfare] a lot […] Because they'll show up with long-standing sexual abuse between siblings or a massive family and they won't call law enforcement. So, then we're calling saying "Hey were you aware that this case is here today?" "No, there's not even a report." And so, then it's almost like we're going backwards […] And I think we all – everybody in this room, despite where or what you do – sees that. Like if it's not one of them [*people in this room*] it can be really difficult.
>
> (SWUSCAC participant 3)

3.5. Contextual factors involved in professional responses

During the focus groups, participants were asked what contextual factors, including child and family characteristics, might affect and shape their responses with these cases. When asked about how the age of the siblings involved might affect responses, participants referred to age in a legal sense; specifically, they discussed whether the child with HSB was under the age of criminal responsibility and

therefore could or could not be subject to the judicial process.

In addition, closeness in the ages of the involved siblings implied a lack of power dynamics, which could compound injury, for some participants:

> I think that typically when siblings are closer in age, there's more of a suspicion or high likelihood that maybe it's more experimental, and they're just like maybe seeing things they shouldn't be seeing and trying it out on each other or … there's more of a, I don't want to use the word consent, but there's more of a consensual figuring stuff out when the kids are closer in age as opposed to the big age difference of 14 and 6.
>
> (EUSCAC participant 4)

Further, participants were asked about the severity of sexual behavior exhibited by the child with HSB and whether their responses would change if the case included penetration. Though they emphasized that the general societal and legal attitude is that penetration points to more severe abuse, group members did not agree that this was automatically true. One perception was that power dynamics between siblings (e.g., use of coercion, force or authoritarian role) was more important than the type of act itself. Others thought that penetration was a symbol of much more complex interaction by the siblings, as described in the next quote.

> I think its general consensus that most people don't discover their genitals and start exploring them and have sex in the same day. And so, we can assume that generally children are probably the same and generally speaking, and so we would be looking at it from a standpoint of how did it get to this level? How did we get to penetration? What other things have happened? What other things have, like these parents either ignored or missed, or you know we're going to be looking for other things that have happened that led up to this.
>
> (SWUSCAC participant 9)

One participant from the EUSCAC also emphasized the multidimensionality of the concept of severity and the various layers it contains:

> So, I mean we could have this scenario, and we feel this is just a little like hand touching, maybe over the clothes, and the six-year-old discloses, you know, anal penetration […] So I think it depends on the type of abuse like you were saying, and what the child discloses and how often it's happening, and you know what that 14-year-old was saying to the six-year-old like "Don't tell anyone" like "You'll get in trouble." I think there's a lot that's plays into this…. the severity part.
>
> (EUSCAC participant 4)

Participants also noted that whether that child with HSB disclosed the sexual behavior and took responsibility influenced their response:

> So I might be willing in that case to come off the most serious charge and give him another charge that would still have him getting the same treatment, but that wouldn't look as bad on his record for the rest of his life … Because he's accepting responsibility and not putting the victim through a trial, which for me is pretty significant, especially when it's a kid.
>
> (EUSCAC participant 3)

Yet even when the child with HSB did not disclose, the SWUSCAC emphasized rehabilitation over disclosure. The SWUSCAC group further noted that reluctance to disclose may be understandable, with reasons including parental pressure not to disclose, the context of the interview, the interviewer, and embarrassment. This was further discussed by the SWUSCAC:

> Could it be the interviewer, too? Is it a boy who, you know, a 14-year-old boy doesn't want to tell a female investigator …Or does he not wanna tell, you know, if his victim was a boy, does he not want to tell a male investigator because he doesn't want to be perceived as, you know, gay or anything like that? … And if mom or dad are sitting next to them in the interview room … well or I don't wanna talk about sex in front of my mom. I'm 50-years-old, and I still don't. I mean, I can't imagine what that's like for a 14-year-old child to sit next to mom in an interview room and have a scary police officer asking me questions. I'm not gonna tell you nothing! Nothing.
>
> (SWUSCAC participant 2)

Other context considered important included whether the child with HSB was themselves previously abused by family members or those outside the family. This was apparent in all CACs and is further emphasized by an EUSCAC participant:

> Think in my mind I sort of look at that person as more of a victim than a child actor […] I stop really looking at the case as like the victim against the perpetrator and more as like how can services be delivered to this family as a whole […] And I start to feel more bad, more for the child actor if it's been happening a lot and there's a pattern, because then it makes me think something significant happened to that person at some point, and they're just traumatized.
>
> (EUSCAC participant 2)

In addition, participants considered whether the children were stepsiblings or blended families, which were considered more difficult to address. This was mostly addressed by the two US CACs. For example, when asked what details are important to know, one of the participants described:

> Important to know, and it may seem silly but, are they biologically related? Is this a stepsibling? Because that can determine the attitude in the home.

<div align="right">(SWUSCAC participant 3)</div>

Finally, parental response to disclosure was considered crucial especially regarding recognition and cooperation, as the quote below indicates:

> You know, they don't want everybody to know this is their children, but are they allowing it to happen or have, have they tried to stop it? You know, if they tried to stop it, we'd be a little bit more understanding, lenient, whatever, but… if it's like, "Yeah, whatever," "You know, it's what they do," then that's when we start looking at their parenting capacities and their skills and … probably upping that safety plan a little bit more.

<div align="right">(EUSCAC participant 5)</div>

All CACs at the three sites talked about allowing parents time to recognize and internalize what happened, realizing that may take time. However, they do expect parents to take active part in believing and supporting their children after disclosure:

> When you talked about having grace with allowing the parents some time to digest this information. And I think that one of the things that, you know, we don't need to tell them the nitty-gritty, verbatim of every piece of a disclosure that's made, but as we continue on with the investigation we're probably gonna get additional information. We're probably going to get some corroborating information. And as we present pieces of the corroborating information to the parents, what is their, um, is that changing their opinion of what happened and are they kind of absorbing that information? And are they intending to take more steps based on it? Or are they continuing to just "nope it didn't happen, nope it didn't happen."

Thus, during their decision making CAC's members in all cites face multiple important factor including age gap, severity, responsibility taking and previous trauma and family functioning.

3.6. Discussion

CACs are designed to mitigate the negative impact of siloed system responses to child abuse by utilizing collaboration among key professional disciplines to facilitate a coordinated response and enhance child victims' wellbeing (Jones et al., 2007; NCA, 2018). The inherent complexity of child abuse cases becomes exacerbated when addressing HSB among siblings. Through focus groups with three CACs in the U.S. and Israel, similarities and distinctions in responding to child HSB across the communities were noted. The analysis yielded five shared themes: HSB is a challenging problem that must be considered a family issue; the importance of safety; the tension between legal and therapeutic procedures; the relationships between professionals internal and external to the CAC; and the impact of contextual factors such as age, responsibility taking or previous traumatic experience. The CACs had many overlapping beliefs and responses, and distinctions among the CACs were primarily on decisions of how to establish safety and when to use legal actions. Interestingly, the distinctions were not between country lines, with greater differences between the two U.S. sites than the U.S. and Israel sites. Further, the range of therapeutic and legal options in the community appeared to affect the choices made.

CAC members from all three sites agreed that parents are central figures in sibling cases, particularly when addressing safety. Parents are responsible for the care and well-being for all their children. When one child instigates harm against a sibling, familial turmoil is inevitable. All of the CACs shared the need to address the family crisis in a way that will instill both safety and support. However, no single safety plan blueprint can sufficiently address the complex factors that must be considering when establishing physical and psychological safety of all family members. Notably, the emphasis on caregivers corresponds with research on treatment for children with HSB, which has found that directly addressing child behavior management and supervision with parents is the strongest factor related to reduction in HSB (St. Amand et al., 2008). Further, the focus groups expressed the need to examine caregivers' responses after disclosure in the context of the situation, as reluctance, anger, and stress are understandable initial reactions and subsequent cooperation. Factors, such as the parents' own history of trauma and involvement in child welfare systems, can influence the home environment, boundaries, and response to the current situation. In addition, the psychological impact on and need for safety of the child victim and context of trauma are of foremost concern when considering safety planning. Finally, the constellation of the family was also noted to further increase the complexity, as HSB among stepsiblings may instigate divided loyalties, rejection of the stepchild who caused harm, and further conflict. Decisions of the MDT members regarding placement, safety, and adjudication often hinged on all of these factors.

A separate theme focused on the interaction between legal and therapeutic responses that appeared to vary depending on local options. All three CACs emphasized that a therapeutic response was the ultimate goal, yet they differed in the process of facilitating treatment for the family. The Israel Exemption Committee is one notable and influential difference. The Exemption Committee's planning process involves evaluating and integrating contextual factors related to all members of the family and the circumstances of the sexual behavior itself (Tarshish & Tener, 2020). If the family fails to follow through with therapeutic interventions, then legal actions are instituted. Although no known exemption committee exists in the U.S., jurisdictions across the U.S. vary in the extent to which they utilize deferred prosecution or diversion to support rehabilitation and avoid extensive legal involvement of juvenile courts with the family. Further, open availability of community evidence-based treatment may have a critical role in the decision-making of the MDT. The EUSCAC was distinct from the other two sites in terms of greater use of legal actions and separate placements of siblings. They were also the only site that reported that access to therapeutic interventions required legal adjudication, suggesting more difficulty at the site in immediately procuring community-based services for children with HSB. Wider availability of treatment believed to be efficacious by the MDT may alter the decisions of professionals by providing greater options.

When therapeutic services are available, buy-in and engagement of parents and other caregivers in the process of safety and

treatment is critical. How can the MDT facilitate engagement? As noted by Shields et al. (2020), factors at the individual (e.g., taboo topic, trauma history), family (e.g., cultural beliefs, history with services), system (e.g., multiple agency involvement, ethnic/racial disparities), and policy levels (e.g., payment for services limited to adjudicated youth, punitive responses) complicate the process of engaging families in treatment for HSB. Parents/caregivers' engagement in therapy is hindered by the stress experienced by family changes and new rules, inherent isolation, distrust of the system, their own grief and fear, and logistical barriers (Yoder & Brown, 2015). Messaging from the professionals who first contact the parents need to inspire motivation by reflecting an understanding of the seriousness of the behavior coupled with a provided path of hope. Research of Yoder and Ruch (2015) on strategies that therapists use to engage families successfully in treatment for HSB of youth can also be generalized to the full MDT: establish empathy, trust, and feelings of safety while empowering the family's strengths to manage difficulties. A high level of caregivers' internal motivation of to help their children can make all the difference in following through with therapy for child HSB (Shields et al., 2020). These messages can be enhanced with resources designed for caregivers (e.g., Bonner, 2009; National Child Traumatic Stress Network, 2009; NCA, 2017a,b; Parent Partnership Board, 2019; Silovsky, 2009), which can subsequently be shared by MDT members in their interactions with families. Support and realistic planning, with attention paid to important individual, cultural, and regional factors, will be needed in order to help parents/caregivers balance the interventions for all impacted family members. Research on messaging and engagement strategies embedded in MDTs across the world is an important area to explore.

The inherent complexity of sibling HSB cases was evident across all centers, with best outcomes achieved through collaborative decision-making of informed partners. Notably, the CACs all discussed the challenges of working with 'external' or non-CAC MDT members (i.e., professional stakeholder who are not core members of the CAC MDT). Given the importance of the collaboration of professionals as part of the MDT, community education will be of key importance in addressing HSB. Inappropriate and even detrimental decisions can be made by professionals who do not have a strong foundation of evidence-informed education on child sexual development, HSB in children, and related topics. Efforts to support MDT informed collaboration to address HSB of youth are ongoing (e.g., NCA, March 2021).

Our focus groups took place prior to the start of the COVID-19 pandemic. However, we feel it is important to consider our results in the context of the effects of the pandemic, which has caused family engagement in services and safety planning to become even more complicated. During stay-at-home orders or quarantines, children who experience abuse in their homes can neither leave during the day nor do they have access to other adults in the community who may help them. In the context of HSB, removing a child with HSB from their home may be the best safety plan for all children involved. However, kinship or foster relations may be economically stressed or facing COVID-19 exposure, thereby making them less able to accept an additional child. Moreover, placing a child with HSB in a county shelter, often a last resort, may be difficult or impossible, considering recommendations for distancing. We must be thoughtful about how best to establish safety within the same home without removing the child with HSB to another setting, which would include greater availability of mental health services for HSB for all youth.

3.7. Limitations

The experiences of three CACs across two nations elucidate strategies to address sibling HSB through MDTs. However, these three CACs are not necessarily representative of all CACs in their respective countries. Indeed, of 351 CACs in the U.S. who completed a survey on youth with HSB, 34% reported that their community believed that addressing children with HSB was not part of their mission (NCA, 2019). Focus groups with CACs who have less experience or motivation to address sibling HSB regarding their management of these cases may yield distinct stories. Additionally, the CAC studied in Israel frequently made use of the Exemption Committee, which is not true for all CACs in Israel. Finally, CACs or MDT responses from countries outside of the U.S. and Israel may generate other management strategies and procedures not noted by any of the current participants.

Other limitations of this study are inherent in the methodology. Focus groups facilitate in-depth understanding where participants share and the dynamics of the MDT can be captured. However, not all MDT members were available at the time of the focus groups, and thus their voices were missing. Further, the openness to share within a focus group in a MDT will be impacted by the level of collaboration underlying their work. Evidence of their collaboration was notable, but there may have been reluctance to share differing viewpoints or disagreements within the focus group framework; this may be more pronounced in CACs whose MDT struggles with teamwork and cooperation. Finally, the way the focus groups were conducted and the instructions given to the participants is that each spoke in turn. Therefore, the quotes represent individual speakers and not a dialogue between two or more participants. It could be that a more dynamic construction of the focus group would have yielded more nuanced innovative knowledge.

3.8. Conclusions and future directions

This study represents initial research on the MDT processes when managing sibling HSB and further examination to enhance understanding about how contextual factors affect these cases is needed. For example, the findings indicate the importance of the parental unit as major players in the CAC response, and more information on parents own history with trauma or previous familiarity with welfare system can facilitate improved decision-making. Questions were raised on best practices to support physical and psychological safety of all children and responses that are family, rather than individual-based decisions. Further research on policies and practices may elucidate flexible guidelines to support consistent and empirically supported decision-making that could enhance outcomes for families. What happens after this initial response and recommendations from the MDT would be fruitful areas to investigate to guide responses and family reunification empirically when separation was deemed necessary for initial safety and well-being, such as examining family framework proposed in Australia (Keane et al., 2013). Further, there are implications for research with

communities that do not have MDTs and have limited therapeutic options for families.

In conclusion, collaborative teams of professionals within the CAC setting are recognizing the need to address the family crisis associated with sibling sexual abuse within their response and prevention of child maltreatment. With the ultimate goals of facilitating the healing of all family members and providing a path for future healthy relationships, CACs are charged with determining what level of systems involvement facilitate that process without becoming a burden or causing deleterious impact. Options available, such as the Exemption Committee, diversion strategies, and access of evidence-based treatment in the local community, impact MDT decision-making. Given the complexities of these cases, a strong foundation of empirically-based knowledge on relevant topics and factors across professionals involved may support collaborative care and responses.

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