

Problematic Sexual Behavior among Children and Youth: Considerations for Reporting, Assessment, and Treatment

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MISSION

To support military families by mobilizing research into practical applications across the spectrum of family support, resilience, and readiness.

PURPOSE

The purpose of Military REACH, a project of the DoD-USDA Partnership for Military Families, is to bridge the gap between military family research and practice. To facilitate the DoD's provision of high-quality support to military families, our objective is to make research practical and accessible. Our team critically evaluates and synthesizes research that speaks to issues of family support, resilience, and readiness. We identify meaningful trends and practical applications of that research, and then, we deliver research summaries and action-oriented implications to military families, direct service helping professionals, and those who work on behalf of military families.

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The Military REACH team was asked to review the literature regarding problematic sexual behavior (PSB) among children and youth. In this report, we first introduce the research on PSB, and then organize the remainder of the report into three sections.

Section I provides a guideline for non-mental health professionals who work with children and youth (e.g., teachers, youth development specialist) regarding how to respond when PSBs are observed and thresholds for reporting PSB.

Section II reviews various intervention approaches for addressing and treating children and youth with PSB. This section provides strong rationale for the use of therapeutic treatment, when warranted, as opposed to labeling children and youth as criminal offenders. Several therapy models for treating PSB among children are reviewed and information is presented regarding treatment effectiveness and training requirements for mental health professionals.

Section III concludes the report with treatment considerations for clinicians who are assessing and working with children and youth with PSB.

This report also contains supplemental materials, included as appendices, which provide resources for those who work with children and youth.

- Appendix A: A Brief Guide to Understanding and Responding to Normative and Problematic Sexual Behaviors among Children and Youth
- Appendix B: Children with Problem Sexual Behaviors Assessment Tool (CD-214) Instructions
- Appendix C: Children with Problem Sexual Behaviors Assessment Tool (CD-214)
- Appendix D: Child Sexual Behavior Inventory (CSBI-3)
- Appendix E: The Assessment Checklist for Children (ACC) Sexual Behavior Subscale
- Appendix F: The Explicit Sexual Interest Questionnaire for Adolescents
- Appendix G: Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR 2.0)
- Appendix H: Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) Manual
- Appendix I: Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORRAT-II)
- Appendix J: Alabama Parenting Questionnaire (APQ)
- Appendix K: Child PTSD Symptom Scale for DSM-V (CPSS-V)

INTRODUCTION

Problematic sexual behavior (PSB) among children and youth¹ is characterized as developmentally inappropriate behavior with sexual body parts that are, at times, harmful to the individual and/or others (Chaffin et al., 2008). There are a wide range of behaviors that fall into the category of PSB. Defining whether a behavior is problematic or not requires contextual considerations, such as the age and developmental stage of the child as well as cultural norms.

As in the broader field of developmental psychopathology, maladaptive behaviors must be examined in relation to normative development for a given life stage. Thus, to understand PSB, we start by examining normative sexual development and typical exploring behaviors among children.

What is Normative Child and Youth Sexual Behavior?

Sexual exploration begins at birth and is a normal part of development as children and youth are naturally curious about their bodies and sex (DeLamater & Friedrich, 2002; Drury & Bukowski, 2013). Depending on developmental stage, there are varying degrees of normative sexual behavior among children and youth (Barbaree & Marshall, 2008; Chaffin, 2008; Elkovitch, Latzman, Hansen, & Flood, 2009). These behaviors may involve information gathering, conversations pertaining to sexual body parts, exploration focused on sexual body parts, and curiosity about sexual behavior (Friedrich, Fisher, Broughton, Houston, & Shafran, 1998).

Normative child and youth sexual behaviors are typically spontaneous and inconsistent. In other words, these behaviors generally do not appear deliberate (e.g., they are not planned or calculated), and they are not regular occurrences. Normative sexual behaviors can be self-focused (e.g., self-stimulation) or include other children; however, not all behaviors including other children are considered normative.

Additional factors must be considered when evaluating sexual behaviors that include the involvement of other children, namely the degree of participation from each child and the age difference between the children.

Normative behaviors would be characterized as mutual participation in sexual exploratory behaviors between children within a similar age group/developmental stage. Even in the context of mutual participation and children of a similar age, normative sexual behaviors among children do not include intercourse or oral sex.

Sexual behaviors of children and youth are commonly viewed on a continuum from normative, healthy behaviors to problematic behaviors that are harmful to self and/or disruptive to others (Shawler et al., 2018). For example, if a child aged six years old, or younger, were trying to look at peer or adult nudity, or looking/touching a new sibling's genitalia, this behavior would likely be normative and considered exploratory in nature. Yet, if a child the same age were asking others to engage in specific sex acts, or pretending toys were having sex, this would be problematic.

Some sexual behaviors, such as poor boundaries and exhibitionism (i.e., exposing oneself), are considered normative at younger ages and infrequent occurrences, but they would be considered problematic if occurring at greater frequency and/or at a later developmental stage (Elkovitch et al., 2009). For example, if a 12-year-old child were self-stimulating in public, that behavior would be considered problematic; whereas, if a three-year-old engaged in a similar behavior, it would be less problematic and even considered normative.

Social and familial norms are also important factors when considering whether a given behavior is normative or problematic. Typically, the occurrence of normative child sexual behaviors decreases with age (after age five), at least in reported incidence. This is likely also due to the child's enhanced awareness of social norms and the need for privacy when engaging in exploratory and self-stimulating behaviors (Friedrich et al., 1998). Additionally, family cultures that are more accepting of sexualized behavior may notice children engaging in normative sexual behaviors more frequently than families where sexual topics are considered taboo.

As we will discuss in later sections, normative sexual behaviors that fall within developmentally appropriate ranges may still warrant attention, redirection, and/or education from caregivers and professionals.

¹Many sources firmly define "children" as 12 years old and younger (e.g., (Chaffin et al., 2008; Silovsky, Swisher, Widdifield, & Burris, 2012), while other sources consider developmental stage and, thus, recognize cases where some 13 and 14-year-olds may also be characterized as children (e.g., Missouri Department of Social Services, 2015).

What Sexual Behaviors are Considered Problematic among Children and Youth?

The Department of Defense (DoD) defines problematic sexual behavior in children and youth as:

“Behaviors initiated by children and youth under the age of 18 that involve sexual body parts (genitals, anus, buttocks, or breasts) in a manner that deviates from normative or typical sexual behavior and are developmentally inappropriate and/or potentially harmful to the individual initiating the behavior or others.”

Sexual behaviors are more likely to be considered problematic when they are characterized by one or more of the following:

- Occur at a higher frequency than is typical given the child’s or youth’s age and development.
- Are preoccupying or are a greater focus of the child’s or youth’s interactions and interests than other behaviors.
- Interfere with the child’s or youth’s social development and/or general functioning.
- Do not respond to caregiver or other adult intervention.
- Involve sexual knowledge, language and/or behaviors that are inappropriate for the child’s or youth’s chronological or developmental age.
- Include aggression, force, threats, or coercion.
- Include intrusive sexual behavior, such as penetration.
- Are deliberative rather than spontaneous or exploratory in nature.
- Include alcohol or other mind-altering substances.
- Involve aggressive or violent pornography.
- Engender strong upset feelings in any other child or youth involved in the behaviors.
- Are non-mutual.
- Occur between children or youth who are distinct in terms of age, cognitive, social, and/or physical development or otherwise demonstrate developmental inequalities.

Additionally, lack of consent, non-mutual behavior, and/or a wide gap in age, or developmental stage, would be considered problematic. There is some discrepancy in the literature as to what constitutes a wide age gap, but generally a two-year or more age gap might be problematic (Chaffin, 2008; Gunby & Woodhams, 2010; Keelan & Fremouw, 2013).

Appendix A provides an extensive review of normative, cautionary, problematic, and severe sexual behaviors among children of varying ages. This appendix is based on an extensive review of the literature and can be used as a tool for parents and professionals to understand and differentiate normative and problematic sexual behavior among children and youth (Chaffin et al., 2008; Elkovitch et al., 2009; Friedrich et al., 1998; Kaeser, DiSalvo, & Moglia, 2000; Kellogg, 2009; Lévesque, Bigras, & Pauzé, 2012; National Center on the Sexual Behavior of Youth, n.d.; Silovsky & Niec, 2002)

SOURCES: Chaffin, 2008; Ey & McInnes, 2018; Grossi, Lee, Schuler, Ryan, & Prentky, 2016; Hall, Mathews, Pearce, Sarlo-McGarvey, & Gavin, 1996; Kellogg, 2009; Miragoli, Camisasca, & Blasio, 2017; Silovsky & Niec, 2002

SECTION I: THRESHOLDS FOR REPORTING PROBLEMATIC SEXUAL BEHAVIORS AMONG CHILDREN AND YOUTH

Determining Severity

Problematic sexual behavior (PSB) among children and youth is characterized as developmentally inappropriate behavior with sexual body parts that are, at times, harmful to the individual and/or others (Chaffin et al., 2008). Because sexual behaviors occur somewhat regularly, especially at younger ages, teachers, childcare professionals, and youth service providers [collectively referred to as “care professionals” throughout the report] need to be well versed in appropriate and timely responses.

In **Appendix A**, we provide a guide to understanding normative and problematic sexual behavior among children and youth. This brief guide provides assessment questions to determine the severity of PSB, examples of PSB, and recommended responses to each of the four classifications of sexual behavior among children and youth, which include *normative*, *cautionary*, *problematic*, and *severe*.

Developmentally normative sexual behaviors are often seen, and expected, among children. They typically occur infrequently, and the child is responsive to redirection (e.g., requests to stop the behavior, education regarding privacy). The appropriate response by care professionals for such normative behaviors includes redirecting and guiding the child’s behavior in the moment, and then noting the context of the situation, the frequency of the behavior, and the child’s response to guidance and distraction. If the behavior is non-responsive to redirection, consider the behavior cautionary.

Cautionary sexual behaviors are characterized as disruptive to others and only moderately responsive to guidance and redirection. When cautionary behavior is observed, it is recommended that care professionals redirect and guide the child’s behavior in the moment. Next, they should discuss their observations with a supervisor to create a plan of action, which may be informal and include close observation and caregiver consultation.

Problematic sexual behaviors are highly disruptive and potentially harmful to others, and they persist even after attempts by care professionals and/or caregivers to distract or redirect. [See below for how to respond to problematic behaviors.]

Severe sexual behaviors often cause harm to others and persist after explicit redirection. Another sign that the behavior should be characterized as severe is when redirection attempts by care professionals and/or caregivers are met with anger from the child. When problematic or severe behaviors are observed, the care professional must first ensure the immediate safety of the child and other children who may be involved. Both problematic and severe behaviors warrant consultation with supervisors and other professionals within the workplace who work with that child. Caregivers should be contacted and included in the creation of an action plan. This action plan may require the assistance of a mental health professional to create a safety plan and/or a therapeutic treatment plan. In some circumstances, a report to child protective services may be necessary, particularly in situations where the behaviors involve harm or exploitation and continue despite intervention. [See below about when to report.]

When to Report?

Identifying normative and problematic sexual behavior is the first step in determining thresholds for reporting child and youth sexual behavior. Not only do adults, specifically professionals working with children, need to recognize appropriate and inappropriate sexual behaviors, but they also need to have clear guidelines as to when further action is needed, and when informal correction is enough.

As previously mentioned, sexual behaviors occur somewhat regularly, especially at younger ages. For example, in a study of early elementary school students, 29 teachers recorded student behaviors across a six-month period and described any behaviors they viewed as being sexual (Kaeser et al., 2000). Of the 703 students observed during this period, 155 students initiated 378 sexual behaviors. In other words, just over 1/5 of the students were observed engaging in a

behavior of a sexual nature at school. These included communicative behaviors (30%), modeling behaviors (14.8%), self-touching behaviors (11.9%), behaviors that involved touching others (24.9%), and “other” behaviors not classified into the previous groups (18.5%).

Researchers classified about half of the behaviors to be normative. Yet, 184 cases (48.7%) were determined to be problematic; of the PSBs observed, only 14.1% were discussed with a colleague and even fewer (4.9%) were reported to the principal.

Another recent study of over 1,000 professionals working with children found that most participants were unaware of the policies and protocols to follow should an incident of PSB among one or more children be observed (The Minnesota Coalition Against Sexual Assault, 2017). Within this same sample, one in five of these adults had observed a child engaging in behaviors involving sexual body parts.

Care professionals regularly report insufficient knowledge and training regarding when and how to report child sexual behavior (Kaesler et al., 2000; The Minnesota Coalition Against Sexual Assault, 2017), and these questions remain a valid concern. Insufficient knowledge about the policies and procedures of responding to child sexual behaviors is likely to precipitate inaction, the dismissal of potentially problematic behaviors, and missed opportunities to intervene.

Table 1. Questions for consideration when sexual behaviors are observed among one or more children or youth to assess the severity of the situation and determine next steps.

Question	Response	
1. Is the sexual knowledge of the child more advanced than his/her developmental level?	Yes	No
2. Did the child’s behavior appear planned and intentional (as opposed to spontaneous)?	Yes	No
3. Does the child’s behavior appear to be part of a pattern of repeated behavior?	Yes	No
4. Does the behavior persist after attempts to redirect the child?	Yes	No
5. When the behavior was identified and redirected, did the child respond in an emotionally unfitting way (e.g., anger)?	Yes	No
<i>If other children were involved, continue to the next 3 questions:</i>		
6. Was coercion or force used?	Yes	No
7. Was there non-mutual participation between children involved (i.e., the behaviors appeared to be driven by one child)?	Yes	No
8. Was there a large age gap between the children involved (2+ years)?	Yes	No

If you answered “yes” to 1-2 of these questions, the child’s behavior likely falls outside of the range of normative childhood sexual behaviors and should be viewed as *Cautionary*. These behaviors require redirection, guidance, and education. Care professionals are encouraged to consult a supervisor, especially when the behavior is not responsive to redirection, and create a plan of action, which may include close observation and caregiver consultation.

If you answered “yes” to 3+ questions, the child’s behavior appears to be *Problematic* or *Severe*. Care professionals must first ensure the immediate safety of the child and other children who are involved. Then, they are encouraged to consult with supervisors and other professionals within their place of employment who also work with the child. Caregivers should be contacted and included in the creation of an action plan. This action plan may require the assistance of a mental health professional to create a safety plan and/or a therapeutic treatment plan. In some circumstances, a report to child protective services may be necessary, particularly in situations where the behaviors involve harm or exploitation and continue despite intervention.

Note: This table is not intended to be a diagnostic or screening instrument. Rather, the questions are meant to help non-mental health professionals consider the scope of the incident observed and determine an appropriate response. In every situation, contextual factors must be considered to fully understand the child or youth’s behavior and determine the severity of that behavior.

Currently, no standard reporting protocol exists for reporting PSB to authorities, such as child protective services. The most widely-cited protocol for reporting PSB among children is now a decade old (see the Report of the Task Force on Children with Sexual Behavior Problems; Chaffin et al., 2008). Suggestions are to first notify parents/caregivers of these behaviors. If parents/caregivers fail to intervene, then care professionals should report the PSB to authorities in cases where the behavior:

1. *has involved significant harm or exploitation, and*
2. *remains serious or persistent* (Chaffin et al., 2008, p. 213).

While these suggestions remain relevant, an updated review of “best practices” is needed to provide more nuanced and specific guidance within the workplace. Care professionals and, in turn the child care setting, would benefit from systematic information provided by employers regarding:

- how to differentiate normative vs. problematic behaviors,
- who to consult within one’s workplace when questionable sexual behaviors are observed (e.g., a flow of information guide that may include supervisors and trained mental health professionals who are on staff),
- how to have difficult conversations with children and their parents, and
- what is needed to make an official report to authorities as most states require the individual who observed the PSB to be the reporter.

Depending on the state, many care professionals are considered mandated reporters of suspected abuse and neglect, meaning they are required by law to report child sexual abuse; however, this does not necessarily include PSB. Additionally, it is important to note that not all PSB among children warrants a report to authorities, even when the behavior requires therapeutic intervention. To review the most recent laws and statutes by state regarding child welfare and mandatory reporters of child abuse and neglect, visit Child Welfare Information Gateway, a service provided by the Children’s Bureau within the U.S. Department of Health and Human Services’ Administration for Children and Families.

To determine whether an incident of PSB requires *intervention*, which might range from education to therapy, or a *report to authorities*, it is necessary to determine if the sexual behavior is problematic given the child’s age and developmental stage. This includes assessing the context, frequency, and severity of the behavior as well as gauging the intentionality or planned nature of the incident(s). **Table 1** provides a series of questions to assist care professionals in evaluating the severity of the behavior and aid in the determination of the next steps. This is not a clinical assessment tool, but rather a guide for non-mental health professionals to utilize when they observe child behavior that is sexual in nature. When utilizing this guide, considerations of contextual factors surrounding the incident are also necessary to determine the severity of the situation. These questions are also reflected in **Appendix A** under Questions for Consideration.

As individuals and organizations create policies about differentiating and identifying PSB, we have identified a few key considerations, followed by recommendations, for creating policies related to PSB. *First*, children who engage in PSB are first and foremost children. *Second*, PSB among children by itself is not a diagnosable clinical condition; rather, PSB tends to be conceptualized in terms of symptoms, antecedents, and available supports at the individual, family and community level. *Third*, motivations, intentions, and culpability differ greatly between children with PSB and adults who perpetrate sexual offending behaviors (Silovsky, Swisher, Widdifield, & Burris, 2012). In fact, the vast majority of children with PSB do not go on to offend in adolescence or adulthood. *Lastly*, children who engage in PSB tend to be highly responsive to redirection and guidance from adults and to treatment (when it is needed). Accordingly, policies aimed at educating and redirecting children, constructively engaging parents, and connecting families with appropriate resources are needed (St. Amand, Bard, & Silovsky, 2008). Also recommended is that care professionals avoid ascribing adult meaning to PSB among children.

Responding to PSB

The previous section provided key questions to consider about reporting PSB. This section provides a broader framework for non-clinical professionals to utilize when responding to PSBs that do not require an immediate

report to authorities (Evertsz & Miller, 2012). The guide incorporates many of the same questions and response behaviors presented previously in the reporting section, but it also provides a greater understanding of the cyclical nature of effectively responding to children who exhibit PSB. In other words, the response of care professionals is a continuous cycle of information gathering, analysis and planning, taking action, and re-evaluating outcomes to effectively educate and redirect the child exhibiting the PSB and, ultimately, provide a safe context for all children. This process is visually depicted in **Figure 1** and described below.

We note that Evertsz and Miller (2012) describe this process as beginning with *information gathering*. However, because the safety of the child and other children involved must be attended to first, we describe the process as starting with *taking action* and continue throughout the cycle.

STEP 1: Taking Immediate Action

The immediate goal is to effectively stop the behavior and redirect the child, and the care professional's response in the moment is critical. Care professionals are encouraged to utilize the following steps to convey in a supportive manner that the child's behavior is not appropriate.

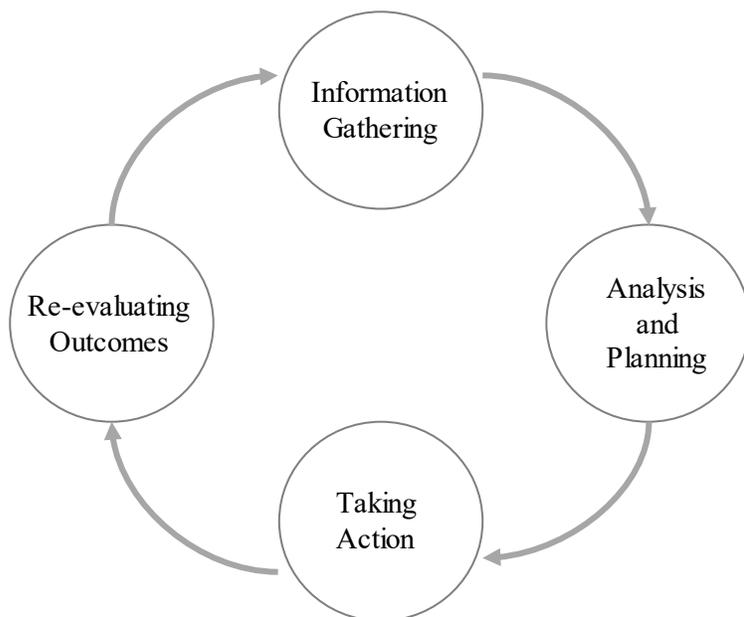


Figure 1. Guide for non-clinical, care professionals to assess and address PSB.

SOURCE: Evertsz & Miller, 2012

- Remain calm and conversational with a “matter-of-fact” tone.
- Clearly and calmly ask the child to stop the behavior.
- Comment on the behavior as opposed to the child (isolate the behavior as the problem, not the child).
- Separate the child and prioritize the safety and emotional well-being of the victim(s) or other children who may have observed the behavior.
- In a location away from other children, provide a firm and clear explanation as to why the behavior is not acceptable and pay attention to the child's response to the explanation.

Note: In cases of severe PSB, the care professional should not question or interview the child or other children in the setting about the incident. Rather, a trained mental health professional is needed. In that situation, the care professional can show concern and listen, but it is not appropriate to ask leading questions.

STEP 2: Evaluating the Immediate Outcome

Take note of the child's response to the redirection. For example: *Did the behavior stop? What was the emotional reaction of the child (e.g., angry, upset, embarrassed)?*

STEP 3: Gather Information

After the incident has concluded and the care professional has ensured the safety of those within the setting, further information gathering is needed to inform next steps.

- Discretely keep a record of the behavior, including the actions themselves, the context, and the date. This will help track the frequency of the behavior.
- Review the key questions for consideration to determine whether the behavior is normative or concerning (see questions provided in **Table 1**).

Care professionals are encouraged to utilize the support of supervisors during the information gathering stage and throughout this process of responding to PSB; if there is a mental health professional on staff, that person may also be of assistance. Care professionals need direct and continuous access to supportive supervisors and therapists to receive regular and constructive feedback.

STEP 4: Analyze Information and Plan Action Steps

Analyze the information gathered to plan action steps. This involves synthesizing the information and accounting for the potential risk of harm in the future. Safety for the child and other children is a primary concern.

Parental engagement is needed when behaviors are not responsive to immediate redirection and guidance. If the situation warrants parental/caregiver attention, create a plan for engaging the parents. Use a supportive, yet direct approach to convey the behaviors that were observed in a factual manner. During these difficult conversations, a warm and empathic tone will encourage a more collaborative relationship between care professionals and parents/caregivers. Enlisting the support of parents is consistently associated with improved behavioral outcomes for children and youth (Silovsky et al., 2012; St. Amand et al., 2008).

Create a plan of action for the care setting. This may include close observation, regularly engaging with parents about progress and updates, and educating the child and/or group about social skills and rules of sexual behavior.

Note: A mental health professional may be needed to create a safety assessment, and, in some cases, referrals to clinical treatment may be needed.

STEP 5: Take Action

Implement the agreed upon action plan, but note that it is not the responsibility of care professionals to implement or evaluate the clinical treatment of children and youth with PSB. If care professionals have adequate knowledge and training, they may have opportunities to teach self-control skills, age-appropriate sex education (e.g., information about private parts, privacy, good touch/bad touch), and/or rules about private parts and sexual behavior.

When possible and permissible, collaborate with others involved in the treatment of the child or youth. This approach is termed a multidisciplinary model of treatment for PSB. This model is a collaborative approach to intervention that includes the engagement of multiple agencies and individuals involved in the situation (e.g., school, other mental health professionals, the State's department focused on children and families,

law enforcement). This 'team' of collaborators allows for a tailored, comprehensive approach to support the child/youth and their family system. For example, information from = care professionals may be useful for understanding patterns of behavior and determining whether the child is implementing the treatment.

STEP 6: Re-evaluate Outcomes and Continue the Process as Needed

After appropriately responding to the initial behavior, it is critical to re-evaluate the child's progress regularly to determine if the response and plan of action is working. Some indicators of progress and positive outcomes include:

1. Reduction in the range, severity, and frequency of problem sexual behavior
2. Improved child well-being
3. Improved family environment
4. Successful enactment of safety plans
5. Improved child adjustment at school and out-of-home care
6. Ability of parents/caregivers to monitor and respond to future inappropriate behaviors

Note: Care professionals are not responsible for cultivating or assessing all these outcomes. Rather, care professionals can support prosocial behavior among children under their care by monitoring child behavior and engaging parental support.

For problematic and severe sexual behaviors that do not respond to intervention, a report to authorities may be the next action step. According to Chaffin and colleagues (2008), a report to authorities is warranted when behaviors involve significant harm or exploitation *and* they are characterized as serious or persistent. **Table 2** provides more detail regarding the circumstances that necessitate a report to authorities.

Table 2. *Child sexual behaviors that warrant a report to authorities.*

Behavioral Criteria	Behavior that involved significant harm or exploitation, AND...	Behaviors that are characterized as serious or persistent
Examples	<ul style="list-style-type: none"> • The sexual behavior has caused significant distress or harm, OR • A child has used physical and/or emotional coercion (can include bribes and/or threats) to gain the compliance or reduce the resistance of another child, OR • The age or developmental difference between the children indicated substantial inequality. 	<ul style="list-style-type: none"> • The sexual behaviors are of an advanced nature such as oral-genital contact or penetration, penile-anal contact or penetration, penile-vaginal contact or penetration, digital contact or penetration of the rectum or vagina, OR • Other sexual behaviors of a less advanced nature that persist despite efforts to correct them or admonitions to stop.

SOURCE: Chaffin et al., 2008, p. 25

SECTION II: INTERVENTION OPTIONS FOR CHILDREN AND YOUTH WITH PROBLEMATIC SEXUAL BEHAVIORS

As clearly indicated by research, children with PSB are at minimal risk to become adult sex offenders, especially if they receive appropriate treatment (Chaffin, 2008; Christiansen & Vincent, 2013; Finkelhor, 2009). In fact, most children with PSB do not become adolescent or adult offenders; rather, their behaviors tend to be adaptable in childhood and highly responsive to education, skills training, and therapy, especially when parents are engaged in the intervention (Dopp, Borduin, & Brown, 2015; St. Amand et al., 2008).

Even for children who exhibit severe PSB, recidivism rates are relatively low. In a large, longitudinal study of juvenile offenders (sexual and non-sexual offenses) where youth were tracked until they aged out of the juvenile system, only 3.65% of first-time sexual offenders re-offended sexually (Christiansen & Vincent, 2013). Additionally, in a critical review of more than 20 studies of children and youth with severe PSB (e.g., child protective services were involved or the offender had been adjudicated), recidivism rates ranged from 0-20% (Keelan & Fremouw, 2013). Findings from recent clinical research also suggest that recidivism rates are further reduced when children engage in therapy, specifically therapy treatments that *engage the family system*, including behavioral parent training and social skills training, and *target both the behaviors and cognitions of the child* (Dopp et al., 2015).

Furthermore, systematic differences exist between adult sex offenders and children with sexual behavior problems (Chaffin, 2008; Silovsky et al., 2012). Though child PSB may resemble adult sexual behavior or adult intimacy, clinicians are strongly encouraged to view children with PSB as children and not through the lens of adult frameworks of sexual offending. Child PSB and the risk of reoffending often stem from various individual, family, social, and developmental factors; this stands in contrast to the motives and intentions of adult offenders and their typical (lack of) responsiveness to treatment.

At times, child PSB is an isolated problem, but often PSB is coupled with:

- disruptive behavior,
- other mental health diagnoses (e.g., internalizing symptoms),
- developmental factors,
- poor coping, or
- any combination of these factors (Elkovitch et al., 2009; Shawler et al., 2018).

Due to this variability in the causes of child PSB and the potential for a range of comorbidities, clinicians recommend comprehensive assessments and individualized treatment plans based on the child's behavioral, emotional, familial, and contextual needs. Individualized treatment plans are those that account for the context and specific needs of the individual child. Individualized treatment plans are not to be confused with what some call "specialized" treatment for child PSB.

Broadly, treatment for child PSB has been conceptualized through a "specialist" or "generalist" lens (Chaffin, 2008).

The *specialist* view suggests that children with PSB, or teen sex offenders, require specialized treatment different from the treatment preferred for other types of problematic behavior. According to Chaffin (2008), the assumption is that these children are part of a unique group of offenders that requires specialized therapy to treat the fundamentally deviant motivation imbedded in their being, as opposed to the assumption that their behavior is malleable and episodic. In some cases, even clinicians have come to believe that treating children with PSB falls outside their scope of expertise, because it requires one to be an expert on PSB.

On the contrary, the *generalist* view proposes that PSB exhibited by children reflects broader difficulties related to self-control, judgement, and the child's social environment. These are skills that most therapists are trained to assess and treat. Chaffin (2008) suggests that, in *most* cases, the generalist

view lends itself to the assessment and treatment of PSB. In other words, responding to PSB in a similar manner used to respond to other types of childhood behavioral problems is sufficient, and even recommended, for most PSB cases. As with the treatment of other types of behavioral problems, it behooves therapists to continually learn about the best practices in treating child PSB to supplement and complement their treatment approach.

Children as Criminal Offenders

Currently in the United States, it is common practice to register adults who are convicted of sex crimes and various PSBs as criminal sex offenders. Policies and underlying assumptions about children with PSB tend to liken them to adult sex offenders in their motivation for offending; therefore, the “legal” responses to such behaviors tends to resemble that of adult offenders. However, there is a growing body of research indicating that children with PSB are inherently different from adult sex offenders (Chaffin, 2008; Silovsky et al., 2012); therefore, it is important for policies to reflect this difference by identifying distinct and appropriate ways of responding to children.

A primary example of the similarity in policies for adult and child offenders is the requirement that minors register as sex offenders (Stevenson, Najdowski, & Wiley, 2013). An adjudication of delinquency (AoD) can trigger a range of registration requirements depending on the state. For example, in Illinois, an AoD prompts registration for a time of 10 years to life, and children are subjected to community notification (Letourneau et al., 2018). The risk of being registered as a sex offender, however, does not appear to prevent or deter PSB among children and youth (Caldwell, 2010; Stevenson, Smith, Sekely, & Farnum, 2013).

Some research has even demonstrated that registering juveniles as sex offenders may actually increase the likelihood of reoffending, in part, because labeling a child as a sex offender (or registering them as a sex offender) is associated with increased hardship and poor well-being (Chaffin et al., 2008; Letourneau et al., 2018). For instance, in a recent study by Letourneau and colleagues (2018) children and youth who also exhibited PSB and were subjected to registering as sex offenders had:

- poorer mental health,
- greater likelihood of attempting suicide within the past month,
- more negative peer experiences,
- less perceived safety, and
- more violent experiences compared to children and youth who also exhibited PSB but were not required to register as a sex offender.

Because little empirical support exists to corroborate the merit for either the child or the community in widely registering children as sex offenders, researchers have generally discouraged the registration of juveniles as sex offenders to reduce ostracizing youth through labels. Rather, case by case consideration is needed, thus acknowledging the complexity and variability of these situations with numerous contextual, individual, and environmental factors at play (Ratnayake, 2013).

The guidelines for determining the registration status of children and youth require flexibility to consider how registration may adversely affect future outcomes and how other approaches, such as evidence-based treatment, may more effectively alter the child’s behavior and promote their positive outcomes.

In sum, despite efforts to reduce recidivism, there has been little to no evidence that juvenile sex offense registration can reduce the risk of reoffending (Caldwell & Dickinson, 2009; Najdowski, Cleary, & Stevenson, 2016), or that registration policies are associated with public safety benefits (Sandler, Letourneau, Vandiver, Shields, & Chaffin, 2017). Notable is that registration has been shown to be both *ineffective in preventing additional offenses and harmful for children*, considering that research has not found systematic public safety benefits for registration policies (Sandler et al., 2017). Because recidivism rates are already low among children with PSB and youth offenders, some believe that registration laws do not deter offenders (Najdowski et al., 2016) and are unnecessary (Letourneau & Armstrong, 2008; Sandler et al., 2017).

Evidence-Based Treatment as a Probable Alternative

Increasingly apparent is that providing offenders with appropriate treatment is the response most likely to create positive outcomes for the offenders, as well as their communities. Because there

are a variety of contexts in which PSB can present, a variety of interventions exist to address these issues. Most treatment models emphasize reducing recidivism, as well as helping children and their families to develop awareness and skills that target the root causes of the problem.

Six treatment models are presented below, beginning with primarily education-based programs and ending with more intensive residential treatments. For each, we present:

- (1) an overview of the treatment model,
- (2) evidence that speaks to the efficacy of the model, and
- (3) implementation considerations.

The models presented include: *Parent-Child Interaction Therapy (PCIT) for Problematic Sexual Behavior*, *Cognitive Behavioral Therapy (CBT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)*, *Multi-Systemic Treatment for Problematic Sexual Behavior (MST-PSB)*, *Multiple-Family Group Intervention (MFGI)*, *The Thought Change System*, and *SafeCare Young People's Program (SYPP)*.

Parent-Child Interaction Therapy (PCIT) for Problematic Sexual Behavior

Overview

PCIT is a psychoeducational and experiential therapy intended for young children (usually preschoolers but can include children between the ages of two and seven) and their parents/primary caregiver (Allen, Timmer, & Urquiza, 2016; Shawler et al., 2018). Interaction and engagement between the child and his/her parent(s) are foundational to the model, which promotes: *relationship enhancement* brought about by child-directed interaction and *caregiver limit setting* evoked from parent-directed interaction. This therapy is grounded in social learning theory and attachment theory and assumes that children change by observing and learning from other people, especially their parents; therefore, in treatment, parent-training is a primary mechanism for ensuring optimal child learning. The model further assumes that a healthy parent-child relationship will positively impact all aspects of child well-being.

Although PCIT has not been formally manualized for addressing PSB, researchers have proposed an adaptation of the therapy that would be reasonably expected to address these issues given the efficacy of the model in other childhood behavior contexts (Shawler et al., 2018). At the beginning of this adapted therapy, an assessment is completed to collect information on the PSB, any other problems the child is exhibiting, and the parent's efforts to address the behavior thus far. Then, a safety plan is created by the therapist in collaboration with the parents to ensure the safety of both the offending child and other children. Next, members of the family are generally educated; such that the parents learn about PSB and healthy sexual development among children, and the child learns about boundaries, appropriate behaviors, as well as emotional regulation. Afterward, the family participates in child-directed interactions, where the parents follow the child's lead in play activities and reinforce appropriate behavior. Lastly, the family participates in parent-directed interactions, where parents lead activities by providing direct and specific instructions to the child, provide positive attention to their child when desirable behaviors are enacted, and administer discipline in a calm fashion. Coaching from therapists provides parents immediate feedback on their relational skills and interactions with their child.

Efficacy

General PCIT not specific to PSB is well supported by evidence in the United States, Australia, and China (California Evidence-Based Clearinghouse for Child Welfare, 2017a). A 2016 meta-analysis showed that PCIT is effective in addressing a variety of complex disruptive behavioral disorders including Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and Conduct Disorder (Ward, Theule, & Cheung, 2016). Furthermore, the therapy has been used in both local agency and in-home formats to effectively train at-risk parent-child dyads, as well as help families where maltreatment has already taken place (Galanter et al., 2012; Timmer, Urquiza, Zebell, & McGrath, 2005). Based on these varying areas where PCIT has been used successfully to help both parents and children with high risk behaviors, multiple experts in the field have suggested that the therapy be adapted to address PSB (Allen et al., 2016; Friedrich, 2007; Silovsky, Niec, Bard, & Hecht, 2007). Allen and colleagues (2016) have even created a treatment protocol for recommended delivery (see **Table 3** below). However, no studies to date have

Table 3. Protocol and techniques for Parent-Child Interaction Therapy (PCIT) for treating problematic sexual behaviors (PSB)

Clinical Assessment and Treatment Planning (2 sessions)	
Session 1	<ul style="list-style-type: none"> – Psychosocial intake: family, placement, medical, and developmental history; functional assessment of behavior; sexual development and behavior^a, history of exposure to sexuality^a and maltreatment history. – Measurement of child behavior problems, PSB^a, trauma symptoms, and parent stress. – Introduction to safety planning, reduce any immediately known risks for future PSB.^a
Session 2	<ul style="list-style-type: none"> – Dyadic Parent-Child Interaction Coding System (DPICS; Eyberg et al, 2014). – Continue safety planning and monitoring supervision^a. – Clinical decision making for treatment model (e.g., elevated PSB and disruptive behavior with no indication that treating any trauma symptoms first would impact outcomes).^a
Teaching about Problematic Sexual Behavior (3 sessions)^b	
Sessions 3-4	<ul style="list-style-type: none"> – Psychoeducation: dispelling myths about PSB in children; sexual development; origins of PSB and disruptive behavior problems. – Behavior plan (reinforcement plan) for child following private part rules paired with teaching a systematic response for caregivers to manage future incidents of PSB (e.g., calmly stop PSB, ensure safety, acknowledge that a private party rule was broken, reminder of reinforcement plan for following private part rules).
Session 5	<ul style="list-style-type: none"> – Parent-child session on body awareness, boundaries, private part rules, abuse prevention, and safety
Teaching Child-Directed Interaction (1 session) & Coaching Sessions (approximately 6 sessions)	
Sessions 6-12	<ul style="list-style-type: none"> – Standard PCIT, CDI teach and coaching sessions with emphasis on labeled praise for boundaries and following private part rules^a; redirection/distraction and selective attention strategies for self-directed, child PSB in the home^a; and how to establish boundaries to prevent PSB^a. – Include PSB directed toward others in the category of aggressive and destructive play^a. – Completion of CDI consists of parent meeting standard CDI mastery.
Teaching Parent-Directed Interaction (1 session) & Coaching Sessions (approximately 6 sessions)	
Sessions 13-19	<ul style="list-style-type: none"> – Standard PCIT, PDI teach and coaching sessions with emphasis on direct commands targeting incompatible behavior with self-directed PSB in the home^a. – Establishment of an automatic consequence for PSB once in PDI session 4 with House Rules^a. – Continued use of behavioral reinforcement plan (i.e., behavior chart for obeying private part rules)^a. – Completion of PDI and PCIT include subclinical elevations in disruptive behavior problems and PSB^a, parental mastery of CDI skills, the PDI skills and procedure, and parental confidence in managing child behavior.
Additional Sessions Pending Assessment and Individual Treatment Goals^b	
Sessions 13-19	<ul style="list-style-type: none"> – Feeling identification and expression – Self-control and emotion regulation skills – Understanding sexual abuse – Family reunification^c

a Represents deviations and points of emphasis not included in the standard PCIT protocol.

b Indicates additional modules not included in the standard PCIT protocol.

c May require additional sessions and assessment, possible to occur throughout treatment.

SOURCE: Allen et al., 2016

empirically examined the use of PSB PCIT treatment for children (see Shawler et al., 2018).

Implementation

The recommendation is that clinicians implementing general PCIT have the equivalent of a master's degree and licensure as a mental health provider as well as 40 hours of intensive skills training and two-to-four supervised cases prior to independent practice. PCIT International provides a certification process to become a recognized PCIT clinician (See <http://www.pcit.org/pcit-certification.html>). In general, a strong understanding of behavioral principles as well as prior training in Cognitive Behavioral Therapy, Child Behavior Therapy, and therapy process skills is also advisable. PCIT-trained providers, then, are encouraged to seek supplemental training in working with children who exhibit PSB (Shawler et al., 2018).

Cognitive Behavioral Therapy (CBT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Overview

Generally, CBT focuses on teaching clients to monitor their own thoughts and behaviors and, then, to replace problematic thoughts and behaviors with more adaptive ones. CBT has been adapted in two ways to treat PSB; they include PSB-CBT for preschool children (California Evidence-Based Clearinghouse for Child Welfare, 2017b; Silovsky et al., 2007) and TF-CBT (Allen, 2018).

The goals of PSB-CBT are to:

- Eliminate or reduce problematic sexual behavior in children and youth
- Improve child behavior via better parental monitoring, supervision, and behavior management skills
- Improve parent-child interaction and communication
- Improve coping, self-control, and social skills in children (California Evidence-Based Clearinghouse for Child Welfare, 2017b).

These goals are met through group treatment, generally 3 to 7 members, with children (approximately 12-14 sessions) that addresses rules of sexual behavior, boundaries, emotion regulation, impulse control,

and problem-solving skills, among others. Parents attend a parallel "parent-training" group focused on understanding child sexual development and ways to effectively improve supervision, implement rules at home, and communicate to children, especially about sex education. Services can be offered to individual families when group context is not appropriate or available.

TF-CBT views most problematic behaviors as reactions to trauma (i.e., a Post-Traumatic Stress Reaction); therefore, TF-CBT focuses on psychoeducation about trauma to help children and youth understand their reactions and experiences, as well as replace adverse thoughts and maladaptive reactions to trauma (Cohen, Mannarino, & Deblinger, 2016). Parents and caregivers are also included in this process, as they are given psychoeducation about trauma, parenting skills, and safety planning. A second focus is teaching coping skills for both children and parents. Allen (2018) provides an overview of the primary components of TF-CBT accompanied by specific techniques for treating posttraumatic stress-related PSB. This information is presented in **Table 4** in the PRACTICE model.

Efficacy

Thus far, there is "promising" evidence regarding the use of PSB-CBT based interventions for treating children with PSB, and it is the most commonly used approach in the United States (California Evidence-Based Clearinghouse for Child Welfare, 2017b; Dopp et al., 2015). A randomized study of 135 children with PSB, ages five to 12, compared play therapy with CBT and showed that over the following 10 years, play therapy participants reoffended at a rate of 10%, while those in CBT had a rate of only 2% (Carpentier, Silovsky, & Chaffin, 2006).

Randomized studies examining the use of TF-CBT among non-offending samples (i.e., children who experienced a trauma) found that it was more effective than general non-directive support therapy in reducing symptomology at one year follow up (Cohen & Mannarino, 1996, 1997) and effects have been identified in as few as eight sessions (Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011). Furthermore, a meta-analytic review determined TF-CBT to be a "wellestablished" treatment for children and adolescents exposed to traumatic events (Silverman et al., 2008). Yet, research on TF-CBT for treating PSB is still in its infancy.

Table 4. Utilizing Trauma Focused Cognitive Behavioral Therapy to treat problematic sexual behavior (PSB) among children and youth with the PRACTICE model

	TF-CBT Component	Techniques for Treating PSB
P	Psychoeducation (information about trauma and trauma reactions)	<ul style="list-style-type: none"> • Provide sexual psychoeducation to the child, including anatomical names of body parts and the process of reproduction • Provide information to the caregivers regarding normative and problematic sexual behaviors in children • Demonstrate for caregivers the connection between the child's posttraumatic stress symptoms and his/her display of PSB.
P	Parenting skills (behavior management skills)	<ul style="list-style-type: none"> • Establish sexual behavior rules with the caregivers and describe these rules for the child. • Develop a behavior management plan that specifies parental responses to PSB. • Develop a safety plan for use in the home and community. • Increase monitoring of the child to reduce the opportunity for PSBs to occur. • Develop the caregiver's ability to effectively communicate with the child, particularly around topics related to sex and sexual behavior.
R	Relaxation skills (Managing physiological reactions to trauma)	<ul style="list-style-type: none"> • Link the use of learned relaxation skills to times when the child is likely to engage in sexual behaviors
A	Affect modulation skills (managing affective responses to trauma)	<ul style="list-style-type: none"> • Teach the child and caregiver impulse control skills, including problem-solving skills. • Encourage and reinforce use of the skills outside of treatment sessions.
C	Cognitive coping skills (connections between thoughts, feelings, behaviors)	<ul style="list-style-type: none"> • Provide examples of hypothetical sexually-based situations and process how thoughts and feelings impact behaviors.
T	Trauma narrative and processing (correcting cognitive distortions related to trauma)	<ul style="list-style-type: none"> • Evaluate and process cognitions of shame, guilt, and selfblame, related to PSB. • Process other potential maladaptive cognitions related to PSB, if observed.
I	In vivo mastery of trauma reminders (overcoming generalized fear related to trauma)	<ul style="list-style-type: none"> • Develop a plan to re-establish trust in the child's ability to not perform PSB. May include building up to unsupervised time with other children.
C	Conjoint child-parent sessions (variety of conjoint child-parent activities)	<ul style="list-style-type: none"> • May be used throughout the protocol to increase communication related to sexual topics, discuss behavior management plans and sexual behavior rules, and practice impulse control and problem-solving skills.
E	Enhancing safety and future development (safety skills and planning for the future)	<ul style="list-style-type: none"> • Emphasize the caregiver's role in preventing sexual abuse, including being vigilant of the people who interact with the child.

Note: In this table, "child" refers to the child or youth who is seeking treatment for PSB.

SOURCE: Allen, 2018

Implementation

Licensed mental health professionals with experience treating young children and their parents would be equipped to implement generalized CBT with children who exhibit PSB. Yet, there is a manual and training process associated with Silovsky's specific PSB-CBT treatment model. Training includes intensive clinical training conducted or approved by an Oklahoma University (OU) PSB-CBT Master Trainer and one year of experience implementing the model with at least four families. Complete guidelines can be requested by contacting OUYPSB@ouhsc.edu.

- Complete the introductory web-based training (available at www.musc.edu/tfcbt for ~\$35)
- Complete the face-to-face introductory training (2-3 days in the person or web-based live training)
- Utilize expert consultations for six to 12 months
- Consider advanced training and certification by the National Association of Cognitive Behavioral Therapists (NACBT) <https://tfcbt.org/tf-cbt-certification-criteria/>

An individual is eligible to apply for Certification in TF-CBT through the National Therapist Certification Program (<https://tfcbt.org/>), if they:

- Have a master's degree in mental health, are licensed in their state, and complete an online training
- Participate in a live training (two days with a national trainer OR six months with a local collaborative)
- Complete supervision (two times a month for six months OR one time a month for 12 months)
- Complete three TF-CBT treatment cases
- Use at least one standardized instrument to assess a case
- Pass the TF-CBT Therapist Certification Program Knowledge-Based Test

Multi-Systemic Treatment for Problematic Sexual Behavior (MST-PSB)

Overview

MST-PSB is a clinical adaptation of MST designed to treat adolescent sex offenders ages 10 to 17 by addressing the variety of systems (people, places,

and situations) to which the adolescent is connected (California Evidence-Based Clearinghouse for Child Welfare, 2016; Pullman & Seto, 2012). Proponents of this model note that treating an adolescent is likely to be ineffective without addressing the key places and people that influence the adolescent; therefore, to the extent possible, this ecologically-based treatment includes people from multiple systems, including home, extended family, school, and peers. Treatment includes:

- intensive family therapy,
- parent training,
- cognitive-behavioral therapy,
- skills building,
- school and other community system interventions, and
- clarification work (e.g., process of accepting responsibility and demonstrating empathy).

There is a manual for implementation, yet MST-PSB emphasizes a service delivery *approach* as opposed to a strict manualized treatment with sequential content (Dopp et al., 2015). The model aims to address problematic behavior at multiple levels, including the *individual* (e.g. social skills training, cognitive restructuring of thoughts about offending), *family* (e.g. caregiver skills training, communication skills training), *peer* (e.g. developing prosocial friendships, discouraging delinquent peer relationships), and *school* levels (e.g. establishment of improved communication between home and school, promoting academic achievement). Teaching new skills is thought to empower the adolescent to navigate their lives in a more adaptive manner. Treatment can include 3+ hours a week for 5 to 7 months.

Efficacy

MST for youth with PSB is well supported by evidence (California Evidence-Based Clearinghouse for Child Welfare, 2016; Dopp, Borduin, & Brown, 2015). A 2013 randomized clinical study revealed that MST improvements in PSB, self-reported delinquency, and out-of-home placements were all maintained at a two-year follow up (Letourneau et al., 2013). Another randomized study compared MST to usual community services for youth with PSB. Youth who completed MST had lower recidivism rates for both PSB (8% for MST, 46% for usual services) and nonsexual crimes (29% for MST, 58% for usual services) in comparison to traditional community services (Borduin, Schaeffer, & Heiblum,

2009). Furthermore, research has shown that increased caregiver follow through and decreased caregiver disapproval of the youth's peer groups mediates the effects of MST treatment (Henggeler et al., 2009). In a longitudinal study that followed juvenile sex offenders for an average of 8.9 years, Borduin and Dopp (2015) estimated the net benefit of MST-PSB over usual community services to be \$343,455 per MSTPSB participant when considering the costs of tax payer expenses (e.g., police/sheriff's office, court process) and the costs to victims (e.g., pain, suffering).

Implementation

The recommendation is that clinicians using this approach are, at a minimum, master's level clinicians with training in behavioral and cognitive-behavioral strategies and pragmatic family therapies, such as Structural or Strategic modalities. Treatment is also likely to be enhanced if the clinician has familiarity with the juvenile justice system, and experience in managing severe family crises and high-risk behaviors (California Evidence-Based Clearinghouse for Child Welfare, 2017).

Formal training is available including a five-day introduction to MST and an additional two-day training pertaining to the MST-PSB clinical model; consultations and booster sessions are available to promote treatment fidelity (<http://www.mstservices.com/resources-training> and <https://www.mstpsb.com>).

Multi-Family Group Intervention (MFGI)

Overview

MFGI is an eight-week intervention conducted with multiple adolescents with PSB and their families, all interacting in group therapy together (Keiley, Zaremba-Morgan, DatuboBrown, Pyle, & Cox, 2015). Theoretically, dysfunctional family attachment patterns influence physiological arousal, which affects behavior; therefore, family relationship dynamics are targeted as a key point of intervention for PSB. Traditionally, this intervention has been carried out for male offenders rather than females. The participants learn skills to cope with physiological arousal and, thereby, facilitate more adaptive decision-making and behavior for both the adolescents and their families. Having multiple families in the same room enables participants to feel less isolated in their struggle, as well as learn from the challenges and successes of others.

Efficacy

Overall, evidence suggests this therapy results in significant decreases in internalizing and externalizing behaviors, as well as significant decreases in attachment anxiety. Furthermore, the 12-month recidivism rate among adolescents with PSB who completed MFGI (N=115) was 4% (Keiley et al., 2015).

Implementation

The type of training required for MFGI does not appear to be publicly available, most likely due to the group focus of the intervention, which requires previous herapeutic training. Those who have been trained in family or group therapy will be the most prepared to learn specific techniques of MFGI (Asen, 2002; Saayman, Saayman, & Wiens, 2006). In particular, clinicians who are proficient in Structural Therapy techniques (e.g., enactments, intensification) will benefit from being able to manage information from multiple groups (Asen, 2002). For those who have clinical backgrounds, training could be accomplished over the course of two to three months and consists of multiple educational seminars, role-playing exercises, and observation of live MFGI demonstrations (Saayman et al., 2006). Finally, although there is no certifying body for MFGI, one can be certified in general group therapy here: <http://www.agpa.org/cgp-certification/how-to-apply>

The Thought Change System

Overview

The Thought Change System is a type of Cognitive Behavioral Therapy that is used in an intensive residential format (Apsche, Evile, & Murphy, 2004). This therapy is geared toward individuals with a history of receiving ineffective treatment (i.e., they have received other therapy that were not effective in producing anticipated changes), generally presenting with a comorbid anti-social personality disorder. The focus of this therapy is to change internal belief systems and to treat the underlying personality disorder to affect problematic sexual thoughts and behaviors. This therapy model includes a combination of individual, family, and group sessions throughout the adolescent's residential stay. Trauma and possible PTSD are considered in the adolescent's engagement in PSB. The adolescent is

taught how certain events can trigger beliefs related to their problematic personality traits, which can lead to PSB. Various relaxation tools are taught to help the adolescent regulate during triggering moments to better balance interpretations and cope with internal stimuli. The theory is that once adolescents can recognize problematic patterns and self-regulate, they will be able to abstain from PSB.

Efficacy

After 12 months of treatment, participants showed a decrease in overt negative behaviors, internalizing behaviors, disturbed behaviors, and aggressive cognition, suggesting changes in both the behavioral and cognitive realms (Apsche et al., 2004). Additional evaluation studies are needed to more fully understand the effectiveness of this treatment program; however, the TCS is a modification of Cognitive Behavioral Therapy which has been attested to be effective by multiple sources (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012; Marques, Day, Nelson, & West, 1994).

Implementation

No distinct certifying body for the Thought Change System approach to PSB exists. Additionally, there is no readily available treatment module or manual for public consumption; however, a pilot study by Apasche and colleagues (2004) suggests a year-long residential treatment program by clinicians trained in various Cognitive Behavioral Therapy techniques. This indicates that implementation of the Thought Change System requires extensive training in clinical work, as well as program specific training.

SafeCare Young People's Program (SYPP)

Overview

The SYPP is a community-based treatment for adolescent sexual offenders who offended against a family member (Thornton et al., 2008). SYPP includes individual and group therapy for the adolescent and each member of the family, couples therapy for parents, family therapy, and reunification assistance (i.e. reunifying the juvenile offender with family if time spent apart was required). Information on the specific theory or techniques for this program is limited.

Efficacy

While evidence for the effectiveness of SYPP is limited, Thornton and colleagues (2008) (2008) reported positive results. Parents in the SYPP reported improved parenting skills through greater awareness of how their role had both positively and negatively influenced family functioning. Parents reported that there was an overall improvement in communication within the family. Most adolescent participants reported better self-control, improved peer and family relationships, and optimism about the future. These preliminary results suggest that the program may be effective, and that further evaluation would be helpful.

Implementation

No distinct certifying body for the SYPP exists, nor do readily available training courses or manuals. The program appears to emphasize specific treatment plans for offenders and their family members, while utilizing Cognitive Behavioral and family therapy techniques (Thornton et al., 2008); therefore, professionals who utilize this program will likely need training in these methodologies as a foundation.

Common Factors Amongst Therapies

Although there are several options for the treatment of PSB, some key commonalities among approaches arise. For instance, several of these interventions utilize cognitive behavioral therapy principles. Additionally, many of these programs suggest utilizing a systemic lens and family therapy approach to address salient relationships and the systems in which the child operates. For adolescents, recommendations are also that physiological and emotional arousal management are key to regulating behavior.

A meta-analysis examining the effectiveness of treatments for PSB verifies this observation about treatment commonalities (St. Amand et al., 2008). From a review of 11 treatment outcome studies that evaluated 18 specific treatments of PSB, researchers found that receiving therapeutic treatment of any kind was associated with almost a half of a standard deviation decline in PSB. ***This implies that a variety of treatment for PSB among children can be effective.*** The meta-analysis also identified particular treatment elements that were associated with declines in PSB, including:

1. *Behavior parent training*, which includes relationship building between parents and children and teaching parents appropriate behavior management strategies.
2. *Teaching rules about sexual behavior to children and families* to directly address expectations for the child's behavior and promote respect for the privacy of others.
3. *Sex education* to clarify misunderstandings and curiosities children may have about the body and sexual behaviors.
4. *Abuse prevention skills* to teach children how to stay safe, especially in situations where someone encourages them to engage in inappropriate sexual behavior.
5. *Self-control skills* to promote prosocial behaviors and decision-making skills.
6. *Family involvement in treatment* as evidence suggests that the primary agent of change for children with PSB was the parents/caregivers (St. Amand et al., 2008)

In sum, many treatment options and therapy modalities could be effective in treating children with PSB, if the treatment is targeting key areas of intervention (i.e., behavior parent training, teaching rules about sexual behavior, sex education, abuse prevention skills, and self-control skills) and invoking the family as an essential means to promote systemic, long-term change. In fact, in a chapter written by Silovsky and colleagues (2012) about clinical considerations for children with PSB, no particular therapy modality was suggested as the premier treatment approach for children with PSB. This is particularly meaningful as Silovsky is credited as a developer of PSB-CBT, a specific treatment approach reviewed above for treating children with PSB. Rather, the focus of their chapter was on (1) recognizing that treatment for children with PSB was different than the treatment for adult sex offenders, (2) identifying the needs of individual children, and (3) creating a treatment plan that emphasizes the individual child's contextual and developmental needs. Section III of this report reviews what is known regarding best practices in assessment and individualized treatment of children with PSB.

After an extensive review of treatment approaches for child PSB, it is the opinion of the authors of this report that a well-trained, systemic child therapist with education regarding PSB in childhood can effectively treat a child exhibiting PSB and the child's family system. Training in specific treatment approaches, such as MST-PSB or TF-CBT, would certainly enhance the skillset of the therapist and provide them certification in a manualized treatment approach. Yet, if PSB in childhood is viewed as another type of behavior problem, then a generalist approach to treatment may be enough for most children.

Training Opportunities

A video training series is provided by the National Children's Alliance (NCA) in partnership with the National Center on the Sexual Behavior of Youth to produce a free, two-hour video training series intended for clinicians at Child Advocacy Centers on addressing youth and children with sexual behavior problems.

Video training series:
<https://www.mrcac.org/elearning/ypsb/>

Video training series supplement - Updated resources on addressing sexual behavior in trauma treatment:
<http://www.nationalchildrensalliance.org/psb/>

SECTION III: ASSESSMENT AND TREATMENT CONSIDERATIONS FOR CHILDREN AND YOUTH WITH PROBLEMATIC SEXUAL BEHAVIORS

This section is geared toward mental health clinicians working with children and youth. As children and youth are identified by a parent, teacher, or other caregiver as exhibiting problematic sexual behavior (PSB), it is necessary for clinicians to effectively assess and treat these children and the family systems in which they live and, where possible, to utilize a multidisciplinary model to comprehensively approach treatment. We begin with a discussion of the etiology of PSB and noteworthy, co-occurring concerns for children with PSB. Then, tools and guiding questions for clinical assessments are provided. Finally, a conversation about the application of assessments to inform therapy is provided along with some treatment considerations.

Etiology of PSB

The etiology and maintenance of PSB is rooted in a combination of *individual factors* (e.g., personal characteristics, biology) and *environmental contexts* (e.g., familial circumstances, economic conditions, cultural perspectives) (Elkovitch et al., 2009). See **Table 5** for further discussion of these factors.

Although these predictors and risk factors have been empirically established, clinicians are encouraged to remember that children with PSB are diverse. Some children may experience all these risk factors and not end up with PSB (a concept known as multifinality), and other children may experience none of these risk factors and still present in therapy with PSB (a concept known as equifinality). No distinct pattern or profile exists for predicting the occurrence of PSB (Silovsky et al., 2012). Silovsky and colleagues present a useful “formula” for conceptualizing the etiology and characterization of PSB:

*Challenging life circumstances + Individual factors =
Children learning the erroneous rules about personal
safety and sexual behaviors*

Comorbidity of PSB

Comorbidity considerations are important for tailoring treatment plans to each child/youth. Though PSB can occur in isolation, often it is accompanied with or exacerbated by other disorders and symptoms; therefore, the recommendation is that assessments and treatment plans should take comorbid disorders into account. These comorbid disorders include:

- a) Trauma-related symptoms
- b) Internalizing symptoms (e.g., depression, anxiety)
- c) Disruptive behavior disorder symptoms (e.g., ADD, ADHD)
- d) Social skills deficits
- e) Learning problems

Contextual stressors that co-exist also need to be accounted for in the treatment planning process, such as:

- f) Child abuse and neglect
- g) Exposure to harsh parenting practices
- h) Exposure to domestic violence

Three clusters of PSB have been identified based on context and co-occurring factors (see review in Shawler et al., 2018). Below we describe these clusters and present their frequency from a study of 151 preschool aged children with PSB (Silovsky, Campbell, & Bard, 2013).

1. **PSB exclusive focus** (23% of preschool children with PSB): Children who exhibit sexual behaviors at a greater frequency than would be expected given their age and context.
2. **Disruptive behaviors** (45% of preschool children with PSB): Children who demonstrate a wide range of disruptive behavior problems which also include PSB. These children are often exposed to challenging family environments, including harsh parenting and/or violence in the home

Table 5. Individual and environmental factors associated with problematic sexual behavior (PSB) among children and youth.

Risk Factors	Research Evidence
Individual-level Factors	
Age	Most juvenile and adult offenders displayed PSB before the age of 12. This does not infer that children under the age of 12 who display PSB are likely to go on to become juvenile offenders, but it does imply that almost half of juvenile offenders first displayed PSB at young ages. Accordingly, there is some discrepancy as to whether age is a potential predictor of PSB and/or risk factor of future offending. It may be that offending at a younger age is an early sign of future offending, but it is likely that the higher rate of recidivism among younger children is developmental in nature (i.e., more PSB occurs at younger ages). For some, PSB in younger children reflects mimicked behaviors that have been observed or experienced by the child.
Sex	Both boys and girls engage in PSB; some patterns suggest a greater prevalence of PSB exists among preschool-age girls, then the pattern changes, such that school-aged boys have a greater prevalence of exhibiting PSB.
Child mental health	Behavior problems, developmental and verbal delays, and impulse control problems are commonly associated with heightened risk of PSB among children. One study found that ¾ of children with PSB also had a disruptive behavior problem or exhibited internalizing or externalizing symptomology.
Environmental Factors	
History of abuse	A common belief is that PSB among children is a result of being a victim of sexual abuse (i.e., the victim becomes the victimizer), yet there is little evidence to support this as a sweeping generalization. We do know that sexual behavior problems have been correlated with experiences of sexual abuse, but only a small portion of the cases of PSB involved children with a history of only sexual abuse (Allen, 2017). Also, it is more likely for younger abusers to have been victims of sexual abuse, but as children age the number of abusers who were victims decreases.
Neglect	Children having experienced neglect or inconsistent supervision may be at a greater risk for PSB.
Exposure to family violence	Exposure to family violence (e.g., physical violence between parents or stepparents and partners) may put children at greater risk for trauma and/or PSB.
Exposure to sexualized media and living in a sexualized environment	Children persisting with PSB are more likely to be living in a highly-sexualized environment. These highly-sexualized environments may inhibit children's understanding of appropriate and inappropriate sexual behaviors; therefore, these children fail to identify and adhere to societal norms regarding sexual behavior.

SOURCES: Allen, 2017; Christiansen & Vincent, 2013; Elkovitch, Latzman, Hansen, & Flood, 2009; Finkelhor, Ormrod, & Chaffin, 2009; Gunby & Woodhams, 2010; Lévesque, Bigras, & Pauzé, 2012; Merrick, Litrownik, Everson, & Cox, 2008; Silovsky & Niec, 2002; Silovsky, Swisher, Widdifield, & Burris, 2012; Tarren-Sweeney, 2008

3. **Complex** (32% of preschool children with PSB): Children present with one or more traumatic experiences, a complex constellation of individual and environmental risk factors, intrusive PSB, and additional mental health symptomology, such as internalizing or externalizing symptomology.

The next section provides considerations for the clinical assessment process when working with children who exhibit PSB. This intake process allows the clinician to account for the child's context and determine the PSB cluster to which the child's symptoms belong.

Clinical Assessment

During a full clinical assessment, clinicians begin by interviewing the child and his/her family to build a comprehensive awareness of the child's PSB (Silovsky et al., 2012). The clinician then conducts an initial safety assessment and a safety plan, if needed. The process of gathering relevant contextual information may take several sessions. These steps are described in greater detail in **Table 6**.

During the information gathering process and the treatment of children and youth with PSB, there is value in utilizing a multidisciplinary model. A multidisciplinary model is a collaborative approach to intervention that includes the engagement of other agencies and individuals involved in the situation (e.g., school, other mental health professionals, the State's department focused on children and families, law enforcement). This 'team' of collaborators allows for a tailored, comprehensive approach to support the child/youth and their family system.

For reference, the Missouri Department of Social Services provides an example of an assessment tool that can be used when working with children with PSB. See **Appendix B** for the tool's instructions, and **Appendix C** for the tool itself.

Assessment Tools

In this section, we provide a brief review of empirically validated measures that can be used during the assessment process to learn more about the child and/or family system. The use of measurement tools as paper/pencil or online surveys is not intended to replace family interviews; rather, they may supplement the

intake process as some children and families feel more comfortable filling out information in survey format.

We examined and assessed numerous measures. None of them alone are sufficient to fully assess the scope and severity of individual cases of PSB among children, but each may contribute to the clinician's understanding of the child and/or family system. We do not advocate that clinicians use any or all of these measures. Rather, we provide these measures as "tools" to be used when needed. To equip clinicians with a "full tool belt" of options, below we provide a list of measures and their intended purpose. When possible, these measurement tools are provided in full as appendices.

Assessment tools for screening child and youth sexual behavior. First, we provide a list of measures that specifically assess for sexual behavior among children and youth.

Child Sexual Behavior Inventory (CSBI). The CSBI (Friedrich et al., 2001, 1992) appears to be the most common measure reflected in the research literature as it is one of the only measures specific to PSB among children. The creators of the measure continue to utilize and conduct research on the measure, so it is well-cited in the research literature. The CSBI is typically for children between the ages of two and 12 who may have been sexually abused. The measure is completed by the primary female caregiver. It assesses the frequency of multiple sexual behaviors across the past six months. It provides an assessment of overall sexual behavior and of nine primary content domains: Boundary Issues, Gender Role Behavior, Sexual Interest, Sexual Knowledge, Exhibitionism, Self-Stimulation, Sexual Intrusiveness, Voyeuristic Behavior, and Sexual Anxiety, accounting for child age and gender. The assessment only takes five to 10 minutes on average to be administered, yet there are regular fees associated with the use of the measure. This scale has a fee – either per use or per device, in which it is installed. See prices.

- The CSBI professional manual and 50 test booklets costs \$219
- The individual manual costs \$70
- CSBI test booklets (25) costs \$84

In **Appendix D**, we provide a review of this measure as presented in a study by Friedrich and colleagues (2001) comparing the use of the CSBI-3 among normative and sexually abused children.

Table 6. Critical components of a clinical assessment for problematic sexual behavior (PSB) among children.

1. Build comprehensive awareness of PSB

Through conversations with the family, the clinician seeks to gather the following information about the PSB. Note: These questions are not intended to be read in script format.

- *Discovery of behaviors* (how were the behavior(s) discovered?)
- *Types of sexual behaviors* (what are the specific behavior(s) of concern?)
- *Location of incident(s)* (where did the behavior(s) occur?)
- *Victims* (were others involved [obtain ages and relationship to child]? If so, what is age difference between the child and the victim? how did the child gain access to the victim?)
- *Severity* (in what ways were force, coercion, and aggression displayed?)
- *Frequency* (how often do these behaviors occur?)
- *Duration* (how long have these behaviors occurred?)
- *History* (what context surrounded the development of these behaviors?)
- *Responsivity to adult intervention* (how has the child reacted to caregiver redirection and guidance?)
- *Social and cultural context of sexual behaviors* (what is the norm regarding sexual development and exploration within the family?)

2. Safety Assessment

Through conversations with the family and sources who referred the case to clinical treatment, determine if there is a safety concern and whether the family system is capable of adequate supervision.

- *Safety* – The potential for harm tends to be enhanced when the PSB involved:
 - a) Physical harm and/or injury
 - b) Emotional distress in the child(ren) involved
 - c) Use of force or coercion when other children were involved
 - d) A sizeable age/development difference when other children were involved
- *Supervision* – Assess for:
 - a) Current supervision standards of the child and his/her siblings (e.g., current supervisor(s), presence of other children, times of limited or no supervision)
 - b) Barriers of the caregiver to provide needed supervision (e.g., parental mental health, substance use, trauma history)

3. Contextual information for treatment and recidivism

Finally, determine other factors that might impede treatment or contribute to recidivism.

- *Child mental health history* (e.g., any comorbid behavioral, emotional, mental, or physical concerns, history of trauma or abuse?)
- *Family composition* (e.g., family members, types and quality of family relationships, whether the victim was within the family system)
- *Parent/caregiver capacity* (e.g., parent/caregiver is capable of enacting the safety plan and supporting treatment)
- *Current school awareness and involvement* (e.g., preschool/school awareness, available supports, safety planning involvement)
- *Other* (concerning and/or protective factors of the child, family, or context)

SOURCES: Gunby & Woodhams, 2010; Keelan & Fremouw, 2013; Silovsky et al., 2012

Assessment Checklist for Children (ACC). The ACC (Tarren-Sweeney, 2007, 2008) is a 120-item caregiver-report scale, that measures behaviors, emotional states, traits, and ways of relating to others, as manifested by children, particularly children between 4- to 11-years old in alternate care settings (e.g., foster care). Specific to this report, the Sexual Behavior subscale is comprised of 11 items that assess age-inappropriate behavior. This measure is included as **Appendix E**.

The Explicit and Implicit Sexual Interest Profile (EISIP). The EISIP measure (Banse, Schmidt, & Clarbourn, 2010) assesses sexual interest. The Explicit Sexual Interest Questionnaire (ESIQ) is most applicable to this report. It is comprised of two subscales answered by the adolescent with suspected PSB: sexual behavior (5 questions, such as “I have enjoyed orally stimulating a man/woman/boy/girl”) and sexual fantasy questions (5 questions, such as “I have daydreamed of having sex with a man/woman/boy/girl”). The “targets” are man, woman, boy, and girl, and the responses are yes or no. This measure is included as **Appendix F**.

Estimate of Risk of Adolescent Sexual Offense Recidivism Version 2.0 (ERASOR). The ERASOR (Kentucky Department of Juvenile Justice, 2001) assesses the risk of future sexual offenses in individuals between the ages of 12-18 who have committed sexual offenses. This measure is included as **Appendix G**.

Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II). The J-SOAP-II (Prentky & Righthand, 2003) is a risk assessment for adolescent boys (age 12 -18) who have demonstrated sexually coercive behavior (i.e., those adjudicated, and those not, but demonstrating sexually-coercive behavior). The manual and measure are included as **Appendix H**.

Juvenile Sexual Offense Recidivism Risk Assessment Tool-II (JSORRAT-II). The JSORRAT-II (Epperson, Ralston, Fowers, & DeWitt, n.d.) is for those over 12 years old and under 18 years old. It is a sexual recidivism risk assessment for those who have been determined guilty of a sexual offense. The manual and measure is included as **Appendix I**.

Other assessment tools for clinicians. Next, we provide a list of measures that assess other factors that may be of interest to clinicians treating children with PSB, including a measure of parenting practices and posttraumatic stress disorder (PTSD) for children.

Alabama Parenting Questionnaire (APQ). The child/adolescent version of the APQ (Frick, Christian, & Wootton, 1999; Shelton, Frick, & Wootton, 1996) is comprised of 42 items assessing parental involvement, positive parenting, poor monitoring/supervision, inconsistent discipline, corporal punishment, and other discipline practices. **Appendix J** provides the child/adolescent version APQ (i.e., it is completed by the child/adolescent). This scale is also available from the parent’s perspective and in an abbreviated format (Elgar, Waschbusch, Dadds, & Sigvaldason, 2007).

Child PTSD Symptom Scale for DSM-V (CPSS-V). The CPSS-V (Foa, Asnaani, Zang, Capaldi, & Yeh, 2018; Foa, Johnson, Feeny, & Treadwell, 2001) is a 27-item measure of posttraumatic stress disorder (PTSD) for children and youth, ages 8-18, who have experienced trauma. The measure is included as **Appendix K**. A score of 31 is used as a cutoff point for identifying probable PTSD. In other words, those with a score of 31 or higher are determined to have PTSD. A 6-item screening version (items 4, 6, 11, 17, 19, and 20) of this measure has also been established to screen for probable PTSD (Foa et al., 2018). A score of 13 or higher on the screening measure reflects a probable PTSD diagnosis.

Applying the Assessment: Treatment Considerations

Once the assessment is completed, the information is utilized to inform the treatment approach beginning with an evaluation of whether the PSB warrants a report to child protective services or the state’s juvenile office. The Missouri Department of Social Services (2015) suggests a referral to the juvenile office when:

- the parent/caregiver of the child with problem sexual behaviors does not engage in the assessment process; or
- there is no evidence that the parent/caregiver is taking steps to prevent future problem sexual behavior; or
- there is a repeated incident of problem sexual behavior by the child; or
- assessment reveals that the child’s behaviors are of such severity that the child cannot be safely maintained in the community.

Table 7. Treatment elements associated with declines in problematic sexual behavior (PSB) and definitions of implementation for children and parents/caregivers.

Treatment Elements	Implementation with Children	Implementation with Parents/Caregivers
<i>Behavior parent training</i>	Children may be involved in parent-child activities, so that the parent may practice implementing behavior parent training skills under the guidance of the therapist.	Parenting strategies designed to reduce problematic child behaviors and increase prosocial and compliant behaviors are taught. Strategies include how to give instructions, reinforcing appropriate behaviors, behavioral charts, selective attention, and consequences, such as time out.
<i>Teaching rules about sexual behavior to children</i>	Teaching basic rules about private parts and sexual behavior and how to apply rules to a variety of situations.	Guidelines for distinguishing typical sexual behavior from PSB and origins of PSB often included.
<i>Sex education</i>	Teaches children information about private parts, physical changes, and reproductive processes. Information about sexual development, sexual orientation, and puberty may be included, particularly with older children.	Caregivers are provided education and address how to promote open communication for sex education as well as addressing relationship building skills and intimacy.
<i>Abuse prevention skills</i>	Teaches about potentially abusive acts and strategies of prevention and self-protection. Often children are taught simple steps to follow in potentially risky situations.	Emphasis is often placed on the role and responsibility of caregivers for protecting their children and determining who supervises and interacts with their children.
<i>Self-control skills</i>	Teaches skills to control impulsive thoughts and behaviors and promote problem-solving and decision-making skills.	Caregivers are taught the steps for self-control and helped to find ways to cue/remind the child to use these strategies in a variety of situations.

SOURCE: St. Amand et al., 2008, p. 152-153

Table 2 in Section I also provides a review of the circumstances in which PSB are to be reported to authorities. Next, although PSB may only be evident of a child in need of behavioral change, because of the complexity of such problematic behavior (the influence of individual and environmental characteristics), it

is often necessary for change to occur within the entire family system. Assessments can assist in the determination of what changes may be necessary for the entire family unit, as well as individual family members, to address and reduce PSB. Treatment considerations may include:

1. Specific behavior training the parents/caregivers need
2. Elements of the family system that pose a barrier to change
3. How family and community strengths can be applied to treatment

Lastly, based on the information clinicians gather, assessments can be applied to identify treatment goals. Questions for consideration might include:

1. What specific rules and education does the child need to understand regarding sexual behavior, sexual development, and appropriate interactions with others?
2. Are abuse prevention skills needed?
3. Where are self-control skills lacking, and how can they be established?

When determining treatment plans, clinicians are encouraged to consider therapy approaches, such as MST-PSB and TF-CBT, and treatment elements that have been empirically linked to reductions in PSB and recidivism rates. See Section II for a review of evidence-based treatments; effective approaches typically emphasize a comprehensive, systemic approach to treatment. As previously mentioned, a meta-analysis examining the effectiveness of treatments for PSB found that parent/caregiver engagement appeared to be the primary agent of change in PSB; it also identified particular treatment elements that were associated with declines in PSB (St. Amand et al., 2008). The treatment elements are summarized in **Table 7**.

Table 8. Advantages and contexts for utilizing each therapy format for treating problematic sexual behavior (PSB) among children

Group Therapy	Family Therapy	Out of Home Placement
<p>Group therapy with other children who have PSB is useful...</p> <ul style="list-style-type: none"> • because it can destigmatize treatment • because sexual behavior problems are often interpersonal behavior problems and it allows for practicing appropriate behaviors with peers in a supported and supervised environment 	<p>This individualized treatment approach is useful ...</p> <ul style="list-style-type: none"> • for individuals who experience symptoms of PTSD may see better results in family therapy compared to group therapy • as a good alternative for complex concurrent issues or during crisis • when there are divorced parents or conflictual relationships, family therapy may better suit these families, so as not to interfere with the other participants in group therapy where families with conflictual relationships may need specialized focus on their conflict 	<p>Removal from the home is useful ...</p> <ul style="list-style-type: none"> • when the home environment is a source of serious distress or when the home environment needs relief from the child with PSB • when reasonable, less restrictive efforts have failed to curtail serious PSB • when there was a lack of reasonable efforts made within the home combined with serious PSB • under exceptional circumstances, e.g., extreme risk or harm to self or others

SOURCE: St. Amand et al., 2008, p. 152-153

There are two main treatment formats for PSB: group therapy and family therapy. **Table 8** reviews contexts in which each of these formats may be useful and warranted as well as when treatment requires removal from the home. In addition to a child's developmental and cultural factors, a child's offense type, psychological symptoms, family dynamic, etc. are important factors in determining a treatment plan. Most children respond positively to community-based, outpatient, short-term treatments, but there are more severe cases that require more intensive approaches to ensure the safety of the child and others.

Conclusion

This report provides a review of the literature on PSB among children and best practices in assessment and treatment. Suggestions are that, in general, PSB exhibited by children reflects broader difficulties related to self-control, judgement, and the child's social environment. Responding to PSB in a similar manner used to respond to other types of childhood behavioral problems is sufficient, and even recommended, for most PSB cases. As with the treatment of other types of behavioral problems, clinicians are encouraged to learn about the best practices in treating child PSB to supplement and complement their treatment approach. Systemic therapy that incorporates key areas of intervention (i.e., behavior parent training, teaching rules about sexual behavior, sex education, abuse prevention skills, and self-control skills) and includes the family as an essential means to promote systemic, long-term change is well-positioned to treat PSB for children. Children with PSB typically respond well to treatment and recidivism rates tend to be low.

References

- Allen, B. (2017). Children with sexual behavior problems: Clinical characteristics and relationship to child maltreatment. *Child Psychiatry & Human Development, 48*(2), 189–199. <https://doi.org/10.1007/s10578-016-0633-8>
- Allen, B. (2018). Implementing trauma-focused cognitive-behavioral therapy (TF-CBT) with preteen children displaying problematic sexual behavior. *Cognitive and Behavioral Practice, 25*(2), 240–249. <https://doi.org/10.1016/j.cbpra.2017.07.001>
- Allen, B., Timmer, S. G., & Urquiza, A. J. (2016). Parent–Child Interaction Therapy for sexual concerns of maltreated children: A preliminary investigation. *Child Abuse & Neglect, 56*, 80–88. <https://doi.org/10.1016/j.chiabu.2016.04.008>
- Apsche, J. A., Evile, M. M., & Murphy, C. (2004). The thought change system an empirically based cognitive behavioral therapy for male juvenile sex offenders: A pilot study. *The Behavior Analyst Today, 5*(1), 101–107. <https://doi.org/10.1037/h0100136>
- Asen, E. (2002). Multiple Family Therapy: An overview. *Journal of Family Therapy, 24*(1), 3–16. <https://doi.org/10.1111/1467-6427.00197>
- Banse, R., Schmidt, A. F., & Clarbour, J. (2010). Indirect measures of sexual interest in child sex offenders: A multimethod approach. *Criminal Justice and Behavior, 37*(3), 319–335. <https://doi.org/10.1177/0093854809357598>
- Barbaree, H. E., & Marshall, W. L. (2008). *The juvenile sex offender*. Guilford Press.
- Borduin, C. M., & Dopp, A. R. (2015). Economic impact of multisystemic therapy with juvenile sexual offenders. *Journal of Family Psychology, 29*(5), 687–696. <https://doi.org/10.1037/fam0000113>
- Borduin, C. M., Schaeffer, C. M., & Heiblum, N. (2009). A randomized clinical trial of Multisystemic Therapy with juvenile sexual offenders: Effects on youth social ecology and criminal activity. *Journal of Consulting and Clinical Psychology, 77*(1), 26–37. <https://doi.org/10.1037/a0013035>
- Caldwell, M. F. (2010). Study characteristics and recidivism base rates in juvenile sex offender recidivism. *International Journal of Offender Therapy and Comparative Criminology, 54*(2), 197–212. <https://doi.org/10.1177/0306624X08330016>
- Caldwell, M. F., & Dickinson, C. (2009). Sex offender registration and recidivism risk in juvenile sexual offenders. *Behavioral Sciences & the Law, 27*(6), 941–956. <https://doi.org/10.1002/bsl.907>
- California Evidence-Based Clearinghouse for Child Welfare. (2016). Multisystemic therapy for youth with problem sexual behaviors. Retrieved July 16, 2018, from <http://www.cebc4cw.org/program/multisystemic-therapy-for-youth-with-problem-sexual-behaviors/detailed>
- California Evidence-Based Clearinghouse for Child Welfare. (2017a). Parent child interaction therapy. Retrieved August 28, 2018, from <http://www.cebc4cw.org/program/parent-child-interaction-therapy/detailed>
- California Evidence-Based Clearinghouse for Child Welfare. (2017b). Problematic sexual behavior cognitive behavioral therapy for preschool children. Retrieved July 16, 2018, from <http://www.cebc4cw.org/program/problematic-sexual-behavior-cognitive-behavioral-therapy-for-preschool-children/detailed>
- Carpentier, M. Y., Silovsky, J. F., & Chaffin, M. (2006). Randomized trial of treatment for children with sexual behavior problem: Ten-year follow-up. *Journal of Consulting and Clinical Psychology, 482*–488.
- Chaffin, M. (2008). Our minds are made up--Don't confuse us with the facts: Commentary on policies concerning children with sexual behavior problems and juvenile sex offenders. *Child Maltreatment, 13*(2), 110–121. <https://doi.org/10.1177/1077559508314510>
- Chaffin, M., Berliner, L., Block, R., Johnson, T. C., Friedrich, W. N., Louis, D. G., ... Madden, C. (2008). Report of the ATSA task force on children with sexual behavior problems. *Child Maltreatment, 13*(2), 199–218. <https://doi.org/10.1177/1077559507306718>
- Chaffin, M., Letourneau, E., & Silovsky, J. F. (2002). Adults, adolescents, and children who sexually abuse children: A developmental perspective. In J. E. B. Myers, L. Berliner, J. Briere, C. T. Hendrix, C. Jenny, T. A. Reid, ... T. A. Reid (Eds.) (Eds.), *The APSAC handbook on child maltreatment*. (pp. 205–232). Thousand Oaks, CA, US: Sage Publications, Inc.

- Christiansen, A. K., & Vincent, J. P. (2013). Characterization and prediction of sexual and nonsexual recidivism among adjudicated juvenile sex offenders. *Behavioral Sciences & the Law*, 31(4), 506–529. <https://doi.org/10.1002/bsl.2070>
- Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(1), 42–50. <https://doi.org/10.1097/00004583-199601000-00011>
- Cohen, J. A., & Mannarino, A. P. (1997). A treatment study for sexually abused preschool children: Outcome during a one-year follow-up. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(9), 1228–1235. <https://doi.org/10.1097/00004583-199709000-00015>
- Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2016). *Treating trauma and traumatic grief in children and adolescents, second edition*. Guilford Publications.
- Deblinger, E., Mannarino, A. P., Cohen, J. A., Runyon, M. K., & Steer, R. A. (2011). Trauma-focused cognitive behavioral therapy for children: Impact of the trauma narrative and treatment length. *Depression and Anxiety*, 28(1), 67–75. <https://doi.org/10.1002/da.20744>
- DeLamater, J., & Friedrich, W. N. (2002). Human sexual development. *Journal of Sex Research*, 39(1), 10–14. <https://doi.org/10.1080/00224490209552113>
- Dopp, A. R., Borduin, C. M., & Brown, C. E. (2015). Evidence-based treatments for juvenile sexual offenders: Review and recommendations. *Journal of Aggression, Conflict and Peace Research*, 7(4), 223–236. <https://doi.org/10.1108/JACPR-01-2015-0155>
- Drury, K. M., & Bukowski, W. M. (2013). Sexual development. In *Handbook of Child and Adolescent Sexuality* (pp. 115–144). Elsevier. <https://doi.org/10.1016/B978-0-12-387759-8.00005-2>
- Elgar, F. J., Waschbusch, D. A., Dadds, M. R., & Sigvaldason, N. (2007). Development and validation of a short form of the Alabama Parenting Questionnaire. *Journal of Child and Family Studies*, 16(2), 243–259. <https://doi.org/10.1007/s10826-006-9082-5>
- Elkovitch, N., Latzman, R. D., Hansen, D. J., & Flood, M. F. (2009). Understanding child sexual behavior problems: A developmental psychopathology framework. *Clinical Psychology Review*, 29(7), 586–598. <https://doi.org/10.1016/j.cpr.2009.06.006>
- Epperson, D., L., Ralston, C., A., Fowers, D., & DeWitt, J. (n.d.). Scoring guidelines for the juvenile sexual offense recidivism risk assessment tool - II.
- Evertsz, J., & Miller, R. (2012). *Children with problem sexual behaviours and their families: Best interests case practice model (Specialist practice resource)*. Melbourne, Australia: Department of Human Services. Retrieved from <https://www.secasa.com.au/assets/Documents/children-with-problem-sexual-behaviours-and-their-families-dhs.pdf>
- Ey, L.-A., & McInnes, E. (2018). Educators' observations of children's display of problematic sexual behaviors in educational settings. *Journal of Child Sexual Abuse*, 27(1), 88–105. <https://doi.org/10.1080/10538712.2017.1349855>
- Finkelhor, D. (2009). The prevention of childhood sexual abuse. *Future of Children*, 19(2), 169–194.
- Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). *Juveniles who commit sex offenses against minors* [Data set]. American Psychological Association. <https://doi.org/10.1037/e630532009-001>
- Foa, E. B., Asnaani, A., Zang, Y., Capaldi, S., & Yeh, R. (2018). Psychometrics of the Child PTSD Symptom Scale for DSM-5 for trauma-exposed children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, 47(1), 38–46. <https://doi.org/10.1080/15374416.2017.1350962>
- Foa, E. B., Johnson, K. M., Feeny, N. C., & Treadwell, K. R. H. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology*, 30(3), 376–384. https://doi.org/10.1207/S15374424JCCP3003_9
- Frick, P. J., Christian, R. E., & Wootton, J. M. (1999). Age trends in the association between parenting practices and conduct problems. *Behavior Modification*, 23(1), 106–128. <https://doi.org/10.1177/0145445599231005>
- Friedrich, W. N. (2007). *Children with sexual behavior problems: family-based, attachment-focused therapy*. W. W. Norton & Company.
- Friedrich, W. N., Fisher, J., Broughton, D., Houston, M., & Shafran, C. R. (1998). Normative sexual behavior in children: A contemporary sample. *Pediatrics*, 101(4), e9–e9. <https://doi.org/10.1542/peds.101.4.e9>

- Friedrich, W. N., Fisher, J. L., Dittner, C. A., Acton, R., Berliner, L., Butler, J., ... Wright, J. (2001). Child Sexual Behavior Inventory: Normative, psychiatric, and sexual abuse comparisons. *Child Maltreatment, 6*(1), 37–49. <https://doi.org/10.1177/1077559501006001004>
- Friedrich, W. N., Grambsch, P., Damon, L., Hewitt, S. K., Koverola, C., Lang, R., A., ... Broughton, D. (1992). Child Sexual Behavior Inventory: Normative and clinical comparisons. Retrieved June 20, 2018, from <http://psycnet.apa.org/buy/1993-04055-001>
- Galanter, R., PhD, S. S.-B., MPH, J. R. V., PhD, S. D., PhD, D. J. W., MSW, M. B.-H., & MSW, M. P. (2012). Effectiveness of Parent–Child Interaction Therapy delivered to at-risk families in the home setting. *Child & Family Behavior Therapy, 34*(3), 177–196. <https://doi.org/10.1080/07317107.2012.707079>
- Grossi, L. M., Lee, A. F., Schuler, A., Ryan, J. L., & Prentky, R. A. (2016). Sexualized behaviors in cohorts of children in the child welfare system. *Child Abuse & Neglect, 52*, 49–61. <https://doi.org/10.1016/j.chiabu.2015.12.014>
- Gunby, C., & Woodhams, J. (2010). Sexually deviant juveniles: Comparisons between the offender and offence characteristics of ‘child abusers’ and ‘peer abusers.’ *Psychology, Crime & Law, 16*(1–2), 47–64. <https://doi.org/10.1080/10683160802621966>
- Hall, D. K., Mathews, F., Pearce, J., Sarlo-McGarvey, N., & Gavin, D. (1996). *The development of sexual behavior problems in children and youth*. Ontario: Central Toronto Youth Services.
- Henggeler, S. W., Letourneau, E. J., Chapman, J. E., Borduin, C. M., Schewe, P. A., & McCart, M. R. (2009). Mediators of change for Multisystemic Therapy with juvenile sexual offenders. *Journal of Consulting and Clinical Psychology, 77*(3), 451–462. <https://doi.org/10.1037/a0013971>
- Hofmann, S. G., Asnaani, A., Vonk, I. J. J., Sawyer, A. T., & Fang, A. (2012). The efficacy of Cognitive Behavioral Therapy: A review of meta-analyses. *Cognitive Therapy and Research, 36*(5), 427–440. <https://doi.org/10.1007/s10608-012-9476-1>
- Kaesler, F., DiSalvo, C., & Moglia, R. (2000). Sexual behaviors of young children that occur in schools. *Journal of Sex Education & Therapy, 25*(4), 277–285.
- Keelan, C. M., & Fremouw, W. J. (2013). Child versus peer/adult offenders: A critical review of the juvenile sex offender literature. *Aggression & Violent Behavior, 18*(6), 732–744. <https://doi.org/10.1016/j.avb.2013.07.026>
- Keiley, M. K., Zaremba-Morgan, A., Datubo-Brown, C., Pyle, R., & Cox, M. (2015). Multiple-family group intervention for incarcerated male adolescents who sexually offend and their families: Change in maladaptive emotion regulation predicts adaptive change in adolescent behaviors. *Journal of Marital and Family Therapy, 41*(3), 324–339. <https://doi.org/10.1111/jmft.12078>
- Kellogg, N. D. (2009). Clinical report—The evaluation of sexual behaviors in children. *Pediatrics, 124*(3), 992–998. <https://doi.org/10.1542/peds.2009-1692>
- Kentucky Department of Juvenile Justice. (2001). Estimate of risk of adolescent sexual offense recidivism. Retrieved from <https://djj.ky.gov/800%20Policy%20Manual/ERASOR%202.0.pdf>
- Letourneau, E. J., & Armstrong, K. S. (2008). Recidivism rates for registered and nonregistered juvenile sexual offenders. *Sexual Abuse, 20*(4), 393–408. <https://doi.org/10.1177/1079063208324661>
- Letourneau, E. J., Harris, A. J., Shields, R. T., Walfield, S. M., Ruzicka, A. E., Buckman, C., ... Nair, R. (2018). Effects of juvenile sex offender registration on adolescent well-being: An empirical examination. *Psychology, Public Policy, and Law, 24*(1), 105–117. <https://doi.org/10.1037/law0000155>
- Letourneau, E. J., Henggeler, S. W., McCart, M. R., Borduin, C. M., Schewe, P. A., & Armstrong, K. S. (2013). Two-year follow-up of a randomized effectiveness trial evaluating MST for juveniles who sexually offend. *Journal of Family Psychology : JFP : Journal of the Division of Family Psychology of the American Psychological Association (Division 43), 27*(6), 978–985. <https://doi.org/10.1037/a0034710>
- Lévesque, M., Bigras, M., & Pauzé, R. (2012). Persistence of problematic sexual behaviors in children. *Journal of Clinical Child & Adolescent Psychology, 41*(2), 239–245. <https://doi.org/10.1080/15374416.2012.651991>
- Marques, J. K., Day, D. M., Nelson, C., & West, M. A. (1994). Effects of Cognitive-Behavioral Treatment on sex offender recidivism: Preliminary results of a longitudinal study. *Criminal Justice and Behavior, 21*(1), 28–54. <https://doi.org/10.1177/0093854894021001004>
- Merrick, M. T., Litrownik, A. J., Everson, M. D., & Cox, C. E. (2008). Beyond sexual abuse: The impact of other maltreatment experiences on dexualized behaviors. *Child Maltreatment, 13*(2), 122–132. <https://doi.org/10.1177/1077559507306715>

- Miragoli, S., Camisasca, E., & Blasio, P. D. (2017). Child sexual behaviors in school context: Age and gender differences. *Journal of Child Sexual Abuse, 26*(2), 213–231. <https://doi.org/10.1080/10538712.2017.1280866>
- Missouri Department of Social Services. (2015). Children with problematic sexual behavior assessment tool (CD-214) instructions. Retrieved from https://dss.mo.gov/cd/info/forms/forminstructions/cd214_instr.pdf
- Najdowski, C. J., Cleary, H. M. D., & Stevenson, M. C. (2016). Adolescent sex offender registration policy: Perspectives on general deterrence potential from criminology and developmental psychology. *Psychology, Public Policy, and Law, 22*(1), 114–125. <https://doi.org/10.1037/law0000059>
- National Center on the Sexual Behavior of Youth. (n.d.). Normative sexual behavior. Retrieved June 21, 2018, from <http://www.ncsby.org/content/normative-sexual-behavior>
- Prentky, R., & Righthand, S. (2003). Juvenile Sex Offender Assessment Protocol-II (J-SOAP-II) Manual, 32.
- Pullman, L., & Seto, M. C. (2012). Assessment and treatment of adolescent sexual offenders: Implications of recent research on generalist versus specialist explanations. *Child Abuse & Neglect, 36*(3), 203–209. <https://doi.org/10.1016/j.chiabu.2011.11.003>
- Ratnayake, A. A. (2013). *Juvenile sex offenses: Finding justice* (National Center for Prosecution of Child Abuse No. Volume 23, Number 9) (p. 4). Retrieved from https://www.ndaa.org/pdf/Update%20Vol23_No9.pdf
- Saayman, R. V., Saayman, G. S., & Wiens, S. M. (2006). Training staff in Multiple Family Therapy in a children's psychiatric hospital: From theory to practice. *Journal of Family Therapy, 28*(4), 404–419. <https://doi.org/10.1111/j.1467-6427.2006.00361.x>
- Sandler, J. C., Letourneau, E. J., Vandiver, D. M., Shields, R. T., & Chaffin, M. (2017). Juvenile sexual crime reporting rates are not influenced by juvenile sex offender registration policies. *Psychology, Public Policy, and Law, 23*(2), 131–140. <https://doi.org/10.1037/law0000118>
- Shawler, P. M., Elizabeth Bard, M., Taylor, E. K., Wilsie, C., Funderburk, B., & Silovsky, J. F. (2018). Parent-child interaction therapy and young children with problematic sexual behavior: A conceptual overview and treatment considerations. *Children and Youth Services Review, 84*, 206–214. <https://doi.org/10.1016/j.chilyouth.2017.12.006>
- Shelton, K. K., Frick, P. J., & Wootton, J. (1996). Assessment of parenting practices in families of elementary school-age children. *Journal of Clinical Child Psychology, 25*(3), 317–329. https://doi.org/10.1207/s15374424jccp2503_8
- Silovsky, J. F., Campbell, C., & Bard, D. (2013, November). *Typology of problematic sexual behavior in early childhood: Presenting symptoms and contributing factors*. Presented at the ABCT Convention, Nashville, TN.
- Silovsky, J. F., & Niec, L. (2002). Characteristics of young children with sexual behavior problems: A pilot study. *Child Maltreatment, 7*(3), 187–197. <https://doi.org/10.1177/1077559502007003002>
- Silovsky, J. F., Niec, L., Bard, D., & Hecht, D. B. (2007). Treatment for preschool children with interpersonal sexual behavior problems: A pilot study. *Journal of Clinical Child and Adolescent Psychology: The Official Journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53, 36*(3), 378–391. <https://doi.org/10.1080/15374410701444330>
- Silovsky, J. F., Swisher, L. M., Widdifield, J., & Burris, L. (2012). Clinical considerations when children have problematic sexual behavior. In *Handbook of Child Sexual Abuse* (pp. 399–428). Wiley-Blackwell. <https://doi.org/10.1002/9781118094822.ch18>
- Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., & Amaya-Jackson, L. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child & Adolescent Psychology, 37*(1), 156–183. <https://doi.org/10.1080/15374410701818293>
- St. Amand, A., Bard, D. E., & Silovsky, J. F. (2008). Meta-analysis of treatment for child sexual behavior problems: Practice elements and outcomes. *Child Maltreatment, 13*(2), 145–166. <https://doi.org/10.1177/1077559508315353>
- Stevenson, M. C., Najdowski, C. J., & Wiley, T. R. A. (2013). Knowledge of juvenile sex offender registration laws predicts adolescent sexual behavior. *Journal of Child Sexual Abuse, 22*(1), 103–118. <https://doi.org/10.1080/10538712.2013.744376>
- Stevenson, M. C., Smith, A. C., Sekely, A., & Farnum, K. S. (2013). Predictors of support for juvenile sex offender registration: Educated individuals recognize the flaws of juvenile registration. *Journal of Child Sexual Abuse, 22*(2), 231–254. <https://doi.org/10.1080/10538712.2013.735354>

- Tarren-Sweeney, M. (2007). The Assessment Checklist for Children--ACC: A behavioral rating scale for children in foster, kinship and residential care. *Children and Youth Services Review, 29*(5), 672–691. <https://doi.org/10.1016/j.chilyouth.2007.01.008>
- Tarren-Sweeney, M. (2008). Predictors of problematic sexual behavior among children with complex maltreatment histories. *Child Maltreatment, 13*(2), 182–198. <https://doi.org/10.1177/1077559508316043>
- The Minnesota Coalition Against Sexual Assault. (2017). *Children with sexual behavior problems: Improving Minnesota's ability to provide early identification and intervention services through policy and practice recommendations*. Retrieved from http://www.mncasa.org/assets/PDFs/RalianceReport_ONLINE_final4_small.pdf
- Thornton, J. A., Stevens, G., Grant, J., Indermaur, D., Chamarette, C., & Halse, A. (2008). Intrafamilial adolescent sex offenders: Family functioning and treatment. *Journal of Family Studies, 14*(2–3), 362–375. <https://doi.org/10.5172/jfs.327.14.2-3.362>
- Timmer, S. G., Urquiza, A. J., Zebell, N. M., & McGrath, J. M. (2005). Parent-Child Interaction Therapy: Application to maltreating parent-child dyads. *Child Abuse & Neglect, 29*(7), 825–842. <https://doi.org/10.1016/j.chiabu.2005.01.003>
- Ward, M. A., Theule, J., & Cheung, K. (2016). Parent–Child Interaction Therapy for child disruptive behaviour disorders: A meta-analysis. *Child & Youth Care Forum, 45*(5), 675–690. <https://doi.org/10.1007/s10566-016-9350-5>

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