ATSA

Children with SEXUAL BEHAVIOR PROBLEMS

2nd EDITION

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Foreword

The Association for the Treatment and Prevention of Sexual Abuse (ATSA) Child and Adolescent Committee is pleased to present this publication *Children with Sexual Behavior Problems (2nd Edition)*. This publication represents an update to the 2006 *Report of the ATSA Task Force on Children with Sexual Behavior Problems*. Pertinent information from the 2006 report has been integrated into this report, along with the results of more recent research conducted and information learned.

The original Task Force on Children with Sexual Behavior Problems was formed in 2006 by the ATSA Board of Directors as part of ATSA's overall mission of promoting effective intervention and management practices for individuals who have engaged in abusive sexual behavior. The Task Force was charged with producing a report intended to guide professional practices with children, ages 12 and under. In the report, the Task Force addressed how the assessment process should be linked to intervention activities, what intervention models or components are most effective, and the role of family involvement in intervention. The Task Force also addresses several scientific and public policy issues concerning children with sexual behavior problems.

The authors of this report are grateful to the task force members for their groundbreaking work in researching and creating the original report. Task force members are listed as authors below, followed by the members of the Juvenile Practice Committee who developed the 2023 version.

On behalf of the ATSA Child and Adolescent Committee the task force members are listed alongside the contributors to this edition.

In collaboration with ATSA Public Affairs Manager, Aniss Benelmouffok.

Sincerely,
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SECTION 1: Introduction

The Association for the Treatment and Prevention of Sexual Abuse (ATSA) Task Force on Children with Sexual Behavior Problems was formed by the ATSA Board of Directors as part of ATSA's overall mission of promoting effective intervention and management practices for individuals who have engaged in abusive sexual behavior. The Task Force was charged with producing a report intended to guide professional practices with children, ages 12 and under. In the report, the Task Force addressed how the assessment process should be linked to intervention activities, what intervention models or components are most effective, and the role of family involvement in intervention. The Task Force also addressed a number of scientific and public policy issues concerning children with sexual behavior problems.

Building on the first edition, this report is about children with sexual behavior problems. We acknowledge the harm that children with sexual behavior problems cause others and we prioritize the needs of those who have experienced harm. However, children who are impacted are not the focus of this report. The UN Convention on the Rights of the Child clearly defines children as anyone under the age of 18. According to this definition, adolescents are children; however, for the purposes of this report, the terms child and children refer to 12 and under.

Definition of Children With Sexual Behavior Problems

This second edition continues with the person-first language used in the first edition. The Association for the Treatment and Prevention of Sexual Abuse (ATSA) prefers person-first language in both practice and in written publications. Person-first language allows us to focus on the child and avoid any bias or assumptions. By prioritizing the individual rather than focusing on the child's behavior, we demonstrate respect and gain a holistic understanding of the child. In this report, we address the sexual behavior problems of children while keeping in mind that the behavior is problematic, not the children themselves. Children are capable of learning better behavior and making good choices with support from family, friends, and professionals (Silovsky et al., 2020).

The Task Force also addressed a number of scientific and public policy issues concerning children with sexual behavior problems. Children with sexual behavior problems are defined as those aged 12 and younger who initiate sexualized behaviors that are developmentally inappropriate or potentially harmful to themselves or others. The phrase "sexual behavior problems" does not refer to a medical or psychological condition or a particular diagnosable disorder. Instead, it encompasses a range of behaviors that can be directed at oneself or directed toward others and that fall outside of acceptable societal limits. These behaviors could also be associated with technology or social media apps.

The range of behaviors involved is wide and can vary in terms of severity and potential to cause harm. Although the term “sexual” is used, the intentions and motivations for these behaviors are multifaceted and could be related to curiosity, anxiety, imitation, attention seeking, self-calming, sexual stimulation, or other reasons (Chaffin, 2006; Silovsky & Bonner, 2003).

Healthy childhood sexual play and exploration is behavior that occurs spontaneously, intermittently, is mutual and noncoercive when it involves other children, and does not cause emotional harm or distress. Healthy childhood sexual play and exploration is not a preoccupation and does not involve advanced sexual behaviors such as intercourse or oral sex. Some degree of behavior focused on sexual body parts, curiosity about sexual behavior, and interest in sexual stimulation is a healthy part of child development. The form of these healthy interests and behavior varies across development and across cultures (Friedrich et al., 2001). What is healthy behavior for a preschooler may be atypical for an older child and vice versa, and what may be tolerated in one culture may be discouraged in another. It should be noted that harmful and intrusive sexual behavior is not normative in any culture (Friedrich et al., 2000; Johnson, 2015; Miragoli et al., 2017).

In determining whether the sexual behavior is unhealthy, consider:

- Whether the behavior is common or rare for the child’s developmental stage and culture;
- Understanding if the behavior violates shared cultural norms/expectations;
- The frequency of the behavior;
- The extent to which sex and sexual behavior has become a preoccupation for the child; and
- Whether the child responds to guidance and correction from adults or continues unabated after healthy corrective efforts.

In determining whether the behavior includes potential for harm, consider:

- The age/developmental differences of the children involved;
- Any use of force, intimidation, or coercion;
- The presence of any emotional distress in the child(ren) involved;
- Whether the behavior appears to be interfering with the child(ren)’s social development; and
- Whether the behavior causes physical injury (Araji, 1997; Hacket, 2014; 1998; Johnson, 2015).

This report addresses sexual behavior problems in a broad sense, with an additional focus on more aggressive and abusive sexual behaviors directed toward other children.

Incidence and Prevalence

Data regarding children with sexual behavior problems are difficult to track because population-based data on the incidence or prevalence of sexual behavior problems in children are not available. Most data exist within child protective services or investigative agencies, and caregivers are typically reluctant for their children to participate in research studies regarding sexual behaviors (Finkelhor et al., 2009). In a study of youth (ages 10-17) and caregivers (for children ages 0-9) who completed the Juvenile Victimization Questionnaire, findings showed that most harmful sexual behaviors were at the hands of other juveniles ages 14-17. The study was conducted in 2008, 2011, and 2014, and included 13,052 participants (Gewirtz-Meydan et al., 2019). Findings also showed that tracking official reports of sexual abuse is complicated due to abuse being unknown to parents or officials. It is worth noting that the data collected did not include sexual abuse that occurred via technology.

The onset sexual behavior problems may occur as young as 3 and 4 years of age (Johnson, 1988, 1989; Prentky et al., 2010; Silovsky & Niec, 2002). During the preschool years, girls appear to be somewhat more likely than boys to be referred for services for sexual behavior problems (Silovsky & Niec, 2002). However, during the school-age period, this trend reverses, with boys predominating by early adolescence (Bonner et al.; Gray et al., 1999; Silovsky et al., 2019).

The types of sexual behavior problems that children demonstrate are more similar across genders than different; children can engage in a wide range of sexual behavior problems including intrusive behaviors (Campbell et al., 2012; Junghans et al., 2012; Smith et al., 2019). Sexual behavior problems often occur with other children with whom they are spending time. This proximity appears to have a stronger influence than the gender of the child, particularly for younger children. Thus, children are commonly known to each other and within their social networks, such as siblings, cousins, schoolmates, or neighbors, and are rarely strangers (DeLago et al., 2020).

No distinct characteristics for children exist, nor is there a clear pattern of demographic, psychological, or social factors that distinguish children with sexual behavior problems from other groups of children (Chaffin et al., 2002). There have been attempts to construct sexual behavior problem subtypes based on the types of sexual behavior problems involved (Bonner et al., 1999; Ensink et al., 2018).

To date, however, the evidence suggests that there are no qualitatively different subtypes of sexual behavior. Instead, there are varying degrees of severity and intensity of sexual behavior problems overall. Children with more frequent and intrusive sexual behavior problems tend to have more comorbid mental health, social, and family problems (Bonner et al., 2005; Hall et al., 1996). Efforts to derive clinically distinct subtypes have yielded empirical clusters with substantial overlap, suggesting that there may not be distinct taxonomic subgroups (Bonner et al., 1999; Lussier et al., 2019; Pithers et al., 1998).

Possible Contributing Factors

Starting in the mid-1980s, theories of the origins of sexual behavior problems emphasized sexual abuse as the predominant, if not sole, cause of sexual behavior problems in children. Children who have been sexually abused do engage in a higher frequency of sexual behaviors than children who have not been sexually abused (Friedrich, 1993; Friedrich et al., 2001; Friedrich et al., 2005; Kendall-Tackett et al., 1993). In addition, sexual abuse histories have been found in high percentages of children with sexual behavior problems (Allen et al., 2015; Friedrich & Luecke, 1988; Hackett et al., 2013; Johnson, 1988; Johnson, 1989; Tarren-Sweeney, 2008).

Sexual abuse may be a contributing factor when it occurs in preschool years, includes penetration, or involves multiple perpetrators (Friedrich, 2002; Friedrich et al., 2003). However, research also suggests that many children with broadly defined sexual behavior problems have no known history of sexual abuse (Allen, 2017).

Using a developmental framework for conceptualizing sexual behavior problems in childhood is a complex and multifactorial process (Elkovitch et al., 2009). According to Elkovitch et al. (2009), factors contributing to the understanding of problematic sexual behavior of children fall into multiple levels. These include the developmental level (e.g., age, gender, biological, cognitive, and learning), microsystem level (e.g., family, including maltreatment and other trauma history, stress, parenting practices, and family circumstances), and exosystem or mesosystem level (e.g., schools, daycare settings, community, and culture) (Lussier & Healey, 2010; Lussier et al., 2019; Silovsky, 2009).

Protective factors—the elements of a child's life that serve to make it less likely that further sexual behavior problems will occur—also exist throughout these multiple levels and are vital for caregivers to bear in mind. These include healthy coping skills, flexible temperament, nurturing parenting practices, quality communication (including addressing sex education) with trusted adults, healthy boundaries, protection from trauma, healthy friendships, and supportive school and community environments (Hackett, 2014; Silovsky, 2009).

Contributing factors occur in many children with sexual behavior problems (Allen, 2017; Hackett, et al., 2013; Pithers et al., 1998; Silovsky & Niec, 2002). Sexual knowledge and behavior are impacted by caregiver, peer, community, and media influences (including sexually explicit material) and responses. Typical normative sexual behaviors (e.g., being curious and sexual play) can remain healthy or become concerning and problematic depending on these responses and influences.

These factors can also include a history of sexual victimization and nonsexual experiences. For example, witnessing and/or experiencing traumatic or otherwise adverse events is often present in the backgrounds of these children. These events can include physical abuse and witnessing violence (Chouinard-Thivierge et al., 2022; Lussier et al., 2019). When a history of sexual abuse is present, the child's response to this experience can be a contributing factor for the sexual behavior problem and is often most accurately conceptualized as a re-experiencing symptom of posttraumatic stress disorder (Allen, 2017; Dillard et al., 2019; Rasmussen, 1999; Rasmussen et al., 1992; Silovsky et al., 2011).

The emotional and behavioral impacts of trauma can play a role in sexual behavior problems. A pattern of nonsexual behavior problems and disruptive behavior disorders is commonly found in children with sexual behavior problems (Allen, 2017; Bonner et al., 1999; Gray et al., 1999; Lévesque et al., 2012; Pithers et al., 1998; Silovsky & Niec, 2002), and has been associated with more persistent and intrusive sexual behavior (Lévesque et al., 2012; Smith et al., 2019).

Emotional dysregulation and behavior problems in children are core after-effects of child maltreatment and complex trauma, leading to a range of challenging behaviors. These include aggression, disruptive behaviors, and sexual behavior problems. Failure to intervene early with the after-effects of trauma can lead to a long-term pattern of behavioral and physical health problems, juvenile delinquency, academic failure, job instability, and overall poor adjustment (Gilbert et al., 2009; Loeber et al., 2000; SAMHSA, 2011). These can, in turn, present a substantial economic burden to society (Fang et al., 2012; Letourneau et al., 2018).

In addition to the findings discussed above, there are individual characteristics that can increase vulnerability to trauma, the likelihood of developing social deficits, and the emergence of disruptive behaviors (Friedrich, 2002; Silovsky, 2009). Interpersonal interactions are complex; delays in language, cognition, social areas, and inaccurate perceptions of social stimuli can hinder children's ability to navigate rules about social interactions, such as boundaries, communication, consent, friendships, and intimacy.

Further, developmental adversity can result in challenges in managing stressors and coping effectively with life events. Children with problematic sexual behavior often have problems at school, issues related to development, behavioral regulation problems, and learning difficulties (British Columbia Ministry of Education, 1999; Horton, 1996; Kenney, 2020). Learning and developmental delays can influence sexual behavior, coping skills, and children's understanding of social norms. These, in turn, can indicate different approaches to best practices for treatment. Socialization difficulties and stigmatizing responses from peers and adults may impede the development of self-concepts (Heiman et al., 1998). Underdeveloped boundaries and indiscriminate friendliness may increase the risk of future victimization (Silovsky, 2009).

Finally, children with sexual behavior problems are at risk of separation from their parents and placement disruptions (Bakermans-Kranenburg et al., 2003; Grossi et al., 2017; N'zi et al., 2017; Tarren-Sweeney, 2008).

SECTION 2: Assessment Overview

This section provides general information to help inform and guide the assessment process for clinicians working with children who have sexual behavior problems and their families. Clinical assessment is a necessary and valuable component of addressing the needs of children with sexual behavior problems and their families. The purpose of such assessments is to:

- Evaluate factors that may have contributed to the individual child's sexual behavior problems; the child's behavioral, emotional, and overall functioning; family dynamics; history of adverse childhood experiences and exposure to trauma as well as protective factors and strengths.
- Provide information to help identify focus areas of treatment as well as inform treatment approaches and strategies.
- Consider whether the children are safe in their environment and adequately protected (i.e., whether the behavior is an indicator of the child being harmed).
- Include information from the family or caregiver and any recommendations for their needs.
- Provide information relevant to safety planning that may aid in formulating official dispositional recommendations and case plans in cases in which child welfare, juvenile justice, legal, or other agencies are involved.
- Determine targets for preventing problematic sexual behavior, reducing safety risks, facilitating protective factors, and promoting healthy, pro-social development.

- Differ from the assessment of adolescents who have engaged in sexually abusive behavior.
- Further considerations include the following:
- Professionals need to be sensitive to differences between children and adolescent and ensure that assessments are developmentally appropriate for the child being assessed.
- Assessors should only utilize testing, instruments, and scales that are developed and tailored specifically for children.
- Clinical assessments regarding sexual behavior problems are not investigative and should not be confused as such or used for investigative purposes such as determining if the behavior occurred or not.
- A clinical assessment regarding sexual behavior problems should play a foundational role in treatment decisions and actions. This includes determining whether there is a need for treatment, recommending the types of treatment needed; recommending treatment priorities; and providing recommendations related to decisions affecting the well-being of the child and the safety and the well-being of the child(ren) the behavior was directed toward and their siblings.

It should be recognized that given the ongoing development of the child and potential changes in circumstances and situations, clinical assessments regarding sexual behavior problems need to be periodically updated. Typically, an assessment regarding sexual behavior problems would not be valid after approximately six months. Any decisions about a child should be made based on updated assessment information.

Scope of Assessment

The scope of a clinical assessment regarding sexual behavior problems in children may vary from case to case due to individual circumstances and situations. An assessment of this type should not occur unless the presence of a sexual behavior problem has clearly been identified. If there is an allegation about inappropriate or abusive sexual behavior that is being investigated by an agency, it is recommended that the assessment should not be conducted until it is evident that the behavior did occur. The breadth and complexity of the clinical assessment regarding sexual behavior problems and the amount of assessment resources consumed will also vary. For most cases, it is unnecessary to conduct broad-ranging assessments with extensive testing across many sessions.

For all assessments, it is necessary to ensure that confidentiality is addressed with the caregiver and/or parent and appropriate consents are obtained as needed. Questions need to be asked at the developmental level of the child and parent and/or caregiver. The overall goal of the assessment is to identify needs, vulnerabilities, and protective factors to guide treatment and safety planning.

Assessors may recommend treatments focused on educating children about sexual abuse, helping children identify who they might tell if they were being abused, having significant adults support this message, and building support systems around the child (Hewitt, 1999). Assessors can also work to address the safety of the child in order to protect everyone from potential consequences of their actions.

Assessor Qualifications

Clinical assessments regarding sexual behavior problems should be conducted by qualified mental health professionals who are licensed appropriate to their discipline and according to local laws. Assessors are expected to have a solid foundation of knowledge in the following areas:

- Understanding of assessment and treatment of children with sexual behavior problems;
- Ability to work with children in a developmentally sensitive way;
- Understanding of the research and literature related to possible factors contributing to sexual behavior problems;
- Child development, including sexual development and behavior;
- Differential diagnosis of childhood mental health and behavioral problems;
- Familiarity with common challenges seen among children with sexual behavior problems;
- Understanding environmental, family, parenting, and social factors related to children's behavior, including those related to the development of sexual and nonsexual behavior problems;
- Familiarity with the current research literature on empirically supported treatment and treatment approaches for childhood behavior and mental health problems; and
- Cultural variations in norms, attitudes, behaviors, and beliefs about childrearing and childhood sexual behaviors.
- Relevant laws and policies regarding sexual behavior of youth in the jurisdictions.

Engaging Caregivers and Children in the Assessment Process

Talking with children and their caregivers about sexual development and behavior should be approached with care. Caregivers may be hesitant to discuss sexual behaviors, and not recognize relevant information. They may be fearful of being judged or struggle with their emotional responses. Children may also be hesitant to discuss their behaviors, not recognize the behavior as sexual, be embarrassed to talk about sexually themed conversations, be afraid of being punished, or experience emotional or behavioral issues that impact their receptiveness to the conversation. Sensitivity to past trauma

history is necessary. The interview atmosphere should be supportive and unpressured. If the child uses sexual terms, the clinician needs to ask for the child's definition of the terms to make sure the behavior is identified correctly. The goals of a clinical interview are gathering information and laying the groundwork for addressing sexual behavior problems in a calm, supportive, and matter-of-fact manner.

When interviewing children, the clinician needs to engage based on that child's development status. Pressure strategies should not be used with the child or their caregiver. Interrogation, polygraphs, or other techniques designed to elicit "confessions" or admission to the behavior should never be used with children. The clinician should address fears, anger, or frustrations. It is not uncommon for children to deny past wrongdoing when questioned by adults. Some children (and their caregivers) may not view the behavior as problematic or may have simply forgotten about past events or details, especially if the assessment occurs many months after the sexual behavior may have happened. Others may experience shame and struggle with talking about the behavior.

For some children, discussing sexual behavior may trigger upsetting memories. Not admitting past sexual behavior problems during the assessment, even in situations where there is clear evidence that the behavior has occurred, is not an indication of poor prognosis. Assessors may decide not to question children about long-past events or details or events that are clearly upsetting to the child, or they may choose not to interview very young children about the specifics of their sexual behavior problem. Assessors might also need to address incorrect beliefs regarding sexual abuse behaviors. The focus of the assessment is to identify current and dynamic strengths and concerns that can inform possible treatment and supervision goals.

Parents, caregivers, and professionals sometimes presume that an assessment must reveal a specific event that caused the sexual behavior problem or that identifying the root cause is necessary for solving the problem. Causes of human behavior can involve the interplay of multiple factors, and all of the contributing factors may not be fully knowable.

Parents or other professionals should be reassured that identifying the ultimate past cause(s) of the sexual behavior problem is far less important than assessing what current and future factors need to be addressed. The assessor must not overlook the possibility that the child with sexual behaviors may be unsafe as well as harming others. All levels of safety need to be addressed and all abuse must end. Assessment reports should provide information about factors present that may be related to sexual behavior problems and protective factors and strengths that can mitigate the problems. The report can also address the well-being of the child and the safety of others.

Assessing Context, Social Ecology, and Family

The context of the behavior, family environment, and social ecology are key areas in assessing all childhood behavior problems (Elkovitch et al., 2009; Wamser-Nanney, & Campbell, 2019). Children's behavior may be triggered by their environment, and changes within the environment may be necessary for sustained changes in behavior. Current and future environmental context may be more influential than individual child factors or the child's specific psychological makeup. One implication of this is that addressing caregiver concerns and fears is crucial. Common reactions from family members include anger, anxiety, self-doubt, defensiveness, shame, or triggering memories of their own trauma. Clinicians therefore need to be respectful of family disclosures and incorporate them into the assessment report as warranted.

Effective treatments for childhood behavior problems typically require working directly with and through parents or other adult caregivers in the child's life. An ecologically focused assessment is critical for determining which goals and strategies can be pursued by key adults in a child's life. In addition, discussion of the social ecology of the extended family, neighborhood, school, and other social environments that directly impact children's behavior should be included in the assessment report.

Ecologically focused assessments strive to identify not only problems and factors that trigger or maintain sexual behavior problems, but they also identify strengths, protective factors, and resources that might be developed to overcome the problems. For example, some children may respond well to treatments emphasizing positive reinforcement and praise while others may respond to increased structure. Protective factors related to families, extended families, peers, communities, and schools should be examined. Ecologically focused assessments also integrate information about permanency planning for children in a jurisdiction's custody. If the child is currently in a nonrelative, out-of-home placement (e.g., foster care, residential), but the long-term plan is reunification with their biological family, assessment and treatment planning should focus on both living situations.

When assessing context, social ecology, and family in regard to sexual behavior problems, the assessor should include a focus on current and future contextual factors both inside and outside the home, including:

- Quality of the caregiver–child relationship, including the level of positive adult caregiver engagement with the child;
- Level of safety in the home for all, including the child who harmed others;
- Adult caregiver capacity and willingness to monitor and supervise behavior;
- Caregiver attachment, warmth, and support shown toward the child;

- Caregiver well-being and current capacity for safety, supervision, and guidance;
- Presence of positive or negative role models and peers in the child's social environment;
- Presence of support person(s) for the caregiver;
- Types of discipline, limits, structure, or consequences applied, the level of disciplinary consistency, and the child's response;
- Emotional, physical, and sexual boundary concerns or issues in the home, school, and community;
- Access to technology to include sexually explicit media;
- Presence of opportunities for inappropriate behavior;
- Extent and degree of exposure to sexual and/or violent stimulation in the child's past and current environments (if applicable);
- Supports for healthy sexual development and identity;
- Exposure to and protection from potentially traumatic situations;
- Cultural factors of the family, home, and community (including racial, ethnic, religious, and socioeconomic factors);
- Factors related to resilience, or protective factors and strengths and resources that can be built on or developed; and
- Current safety plans in place by court officials or family driven.

Assessing Broad Psychological and Behavioral Status

Best practice assessments of children with sexual behavior problems include a broad focus on general behaviors and psychological functioning, as well as a specific assessment of the sexual behavior problems. In some cases, a sexual behavior problem may be the dominant concern, whereas in other cases it may be a secondary issue or lower priority. Combining a broad assessment of general functioning with a specific assessment of sexual behavior supports clinically informed conceptualization.

An array of nonsexual problems can occur among children with sexual behavior problems, including externalizing behaviors, internalizing problems, developmental and learning issues, and the sequelae of adverse experiences. Common problems related to abuse or trauma may include posttraumatic stress disorder, adjustment disorders, other anxiety disorders, and depression. Depending on the child, more specialized assessment procedures, such as assessment of intellectual or learning functioning, may be appropriate. Less often, children with sexual behavior problems may present with a serious mental health diagnosis or can exhibit behavioral disinhibitions.
As a general principle when conducting an assessment, providing common explanations for behavior involving more prevalent conditions should be considered before offering explanations based on rarer conditions.

Assessing Sexual Behavior and Contributing Factors

To the extent possible, obtaining a clear description of the sexual behavior problems involved is core to the assessment. This includes identifying if the behaviors are self-focused, interpersonal, and involved electronic or online behavior, when they began, when they have occurred, how frequently they occur, where they occur, and how and whether they have progressed or changed over time. Assessments should also obtain information about the ages of others involved and their relationships with the child. Information about possible antecedents to the behaviors, how adults have responded to the behavior, what approaches have been tried, along with the child's response to these efforts, is also critical information.

It is often informative to develop a chronological understanding of the sexual behavior history and, if possible, to compare this chronology with key events in the child's life. Information about how the behavior became known, how the adults responded, and how that impacted subsequent behaviors is helpful for the assessment and safety planning. To create a complete picture of the sexual behavior problem, it is indispensable to consult multiple information sources whenever possible and with appropriate permission, including information provided by the child, parents or caregivers, teachers, child welfare workers, agencies, and other professionals or adults involved. This information may be obtained from official reports, records, or evaluations the assessor has access to or by verbal communication. Team meetings with everyone involved in the case can also be used to gather information for the assessment. It should be recognized that while an involved investigative agency may be able to share some relevant information, it may not be appropriate for records to be released if they are specific to the child the behavior was directed toward and therefore confidential to them.

One aspect of an assessment is determining the extent to which the pattern of sexual behavior problems is self-focused, interpersonal, planned, aggressive, internet based, or coercive. For example, sexual behaviors that are self-focused, such as excessive self-touching of genital(s), may suggest a different treatment plan from sexual behavior problems that are interpersonal and unwanted by other children or involve use of force with others. In instances of self-touching, a medical consultation or evaluation may be warranted to screen out a medical condition related to the behavior. In instances involving sexual behavior problems via technology, assessment questions need to focus on aspects of access to technology, length of time spent on technology, what the child has been exposed to, and any safety measures in place.

If the sexual behavior problem is interpersonal, it is helpful to know how the behavior was initiated, the degree of planning or impulsivity, the level of force or coercion, use of objects, use of technology including recording devices, and the strategies used to maintain secrecy. These factors are critical in assessing the extent of supervision and restrictions needed to help develop a plan that allows all children to be safe. Sexual behavior history should include attention to prior efforts or lack of efforts made by adults, parents, and/or caregivers to correct the behavior and the child's response to these efforts. Assessment of corrective efforts that have shown some degree of success may offer insight into key elements of an effective treatment plan.

Assessments should attempt to identify situations or circumstances in which sexual behavior problems occur. For example, some children might engage in sexual behavior problems during times of stress, when depressed or frightened, when angry, or when memories are triggered about their own past abuse or trauma. Others may engage in sexual behavior problems in response to environmental triggers, such as being exposed to sexual stimuli or engaged in physical activities like wrestling with other children.

Still others may show behavior limited to opportunistic circumstances, such as behavior occurring during sleepovers or when sharing a bed with another child. Understanding initial contributing factors or the etiology and course of the behavior may be informative in developing safety plans and conceptualizing the case.

Assessing the Best Interests of Children With Sexual Behavior Problems

Assessors strive to make recommendations that consider the best interests of the child as well as the interests of the family, other children, and the community. It should be recognized and understood that the sexual behaviors do not define the child. Therefore, it is recommended that an assessment include some description of how decisions related to treatment, supervision, or placement might negatively affect the child. Where questions of removal or placement are involved, or where more restrictive or burdensome treatments are being considered, in addition to outlining how the treatment could be beneficial, the assessment should describe the potential burden on the child and the potential risks to which the child might be exposed. For example, where residential or out-of-home placement is considered, assessors should evaluate the potential for any negative social, educational, or familial impact on the child, and evaluate the potential benefits to the child and the importance of protecting other children and the community. The younger or more vulnerable the child, the more emphasis should be given to their best interests and welfare. Safety and well-being for all involved are priorities.

Assessing Histories of Abuse and Neglect

When a child exhibits a sexual behavior problem, it is appropriate for assessors to make direct inquiries into whether or not the child has been, or is being, sexually abused. However, assessors should not presume that the existence of sexual behavior problems, even those involving clearly adult-like sexual behaviors, is sufficient to conclude that there has been sexual abuse (Allen, 2017; Friedrich, 2002; Silovsky, 2009). Assessors should also be aware that it is not their job to act as investigators.

If an investigation is pending, assessors should refrain from asking questions regarding trauma until the investigation is complete. Evidence suggests that there are multiple pathways to sexual behavior problems, some of which involve sexual abuse and some of which do not. The presence of childhood sexual behavior problems is a sufficient reason to raise the question of sexual abuse, but by itself, it is insufficient to conclude that sexual abuse has occurred.

Inquiring into a child's abuse and neglect and trauma history should be done carefully in simple language that the child can understand. Clinicians should favor open-ended questions, assiduously avoid biased, suggestive, or leading questions, and should be responsive to the child's level of distress. Inquiries into the child's trauma history should be made both with the child and with their parents or caregivers. Inquiry into possible trauma or neglect history may or may not lead the assessor to conclude that there is sufficient reasonable suspicion to warrant making a report to the authorities. Assessors are cognizant of any mandated reporting obligations and should inform children and parents/caregivers of the same prior to any assessment. Assessors should inform parents/caregivers about reporting obligations when obtaining consent for the assessment and prior to conducting the evaluation. In families with multigenerational histories of trauma, clinicians should be aware that a child's parent might also experience difficulties with language-based inquiry, memory, and executive functioning skills that have gone unnoticed or unaddressed.

The Role of Formal Testing in the Assessment Process

The use of testing, including standardized psychometric measures, is often helpful as a component of the overall assessment process. Professionals conducting the evaluation should use only those tools for which they meet the qualification level. However, the proper use of psychometric tools involves more than meeting the qualification level. It also involves practicing only within the parameters of one's license and skill set, being well informed of available tools and their psychometric qualities and limitations, having a thorough understanding of the instrument's manual, adherence to appropriate administration and interpretation of the tool, and completion of any needed training related to its use and interpretation.

As noted, the use of formal screenings or standardized psychometric measures when assessing children with sexual behavior problems can be helpful; however, the use of available tools and instruments should be tailored to the individual case. It is common to use a validated trauma scale and measures assessing sexual behavior. In addition, measures related to internalizing and externalizing symptoms disorders and measures related to parental and family functioning should also be considered; these can enhance the assessment and provide additional information relevant to the conceptualization of the case. It is also helpful to use protective factors scales.

Perhaps the most commonly used general measures include behavioral checklists related to the child's general behavior. These are completed by the caregiver and often by the school and, at times, by the child, depending on their age. Measures focused on the parent/caregiver's functioning and level of stress may also be informative, especially given that the child's caregivers and home environment play a vital role in helping a child manage sexual behavior.

Additional Factors Relevant to the Assessment

Children's behavior and status can change over time as they develop and mature, and as their circumstances and social environment change. Consequently, assessment reports can become less valid over time. Child assessment reports often include explicit statements to guard against inappropriate use of the report long after its validity has expired. Clinical assessments are typically considered to only be valid for six months. This is particularly important for assessments of children with sexual behavior problems, given that others may assume or have inaccurate information that leads them to believe the child will continue to engage in the behavior and exhibit more abusive sexual behavior as they get older.

Clinicians have an opportunity to educate others with accurate information about children with sexual behavior problems and by ensuring their assessment report clarifies not only factors or concerns but also protective factors and reminders that decisions should be adjusted in accordance with changing circumstances. This is especially important when making recommendations to limit contact with other children or similarly restrictive interventions. The assessment report should be explicit that the recommendations apply to current circumstances only and should emphasize that any recommended restrictions or safety rules need to be adjusted based on the child's progress and behavior going forward.

In addition to these caveats, other temporal and maturational factors need to be considered during an assessment. As a general principle, behaviors that occurred recently should be given greater weight than behaviors occurring in the distant past.

This is particularly relevant in cases where the inappropriate or abusive sexual behavior occurred in the past, but a thorough inquiry suggests that the behavior has not repeated itself after an extended period of time.

For example, children may be referred for assessment due to sexual behavior problems that last occurred more than a year ago, and it appears the sexual behavior problem has not reoccurred since then. In these circumstances, an assessment would appropriately give greater weight to the child's more recent discontinuation of the behavior than a long-past history of the problem.

Furthermore, in situations where the occurrence of a sexual behavior problem has decreased due to a dramatic but temporary change in the child's environment, long-term maintenance of improved behavior will require assessing not only the child's current emotional and environmental circumstances, but also the future circumstances likely to be involved when the temporary environmental change ends. Therefore, best practice assessments in these cases will include identifying factors that maintain and facilitate safety, both in the temporary living environment and in the anticipated future living environment.

An assessment provides a deeper understanding of the individual child's situation and circumstances and needs. Important points to consider include the following:

- Information obtained during an assessment directly informs safety strategies, focus areas of treatment, approaches, and interventions.
- An assessment should be tailored to the individual case with some situations warranting more extensive assessment than others.
- It is crucial that assessments use only developmentally appropriate measures and procedures that are relevant to the purpose of the evaluation.
- Assessment protocols, measures, or tools intended for use with adolescents (including those intended for adolescents who have engaged in sexually abusive behavior) are typically not appropriate for use with children. Assessors should guard against projecting adolescent constructs onto children.
- Assessors should be knowledgeable about child development and about children with sexual behavior problems. They need to stay current with the literature and research relevant to children with sexual behavior problems.
- It is not the assessor's role to move beyond clinical inquiry into the task of abuse investigation or investigative interviewing. The assessor is responsible for reporting reasonable suspicions.

SECTION 3: Treatment Approaches and Other Interventions

As previously discussed, children with sexual behavior problems are a diverse group whose treatment needs will vary. Treatment is a broad term which encompasses a range of types of interventions designed to support change in a child's functioning, behavior and wider social context and environment. It often is associated with therapy or therapeutic work with children, but increasingly, it is recognized that effective treatments also include attention meet the needs, vulnerabilities, protective factors, and strengths of both the individual child and their family and respond to the variety of issues that may be present (Chaffin, 2008). The sexual behavior problems may or may not be the primary priority within treatment. However, if sexual behavior problems are part of the treatment goals, cognitive behavior therapy (CBT) with active caregiver involvement has been found to ameliorate sexual behavior problems (Silovsky et al., 2019).

An assessment directs and informs treatment intensity, treatment focus, and the identification of what evidence-informed treatments are most appropriate for the individual case. Given that children's needs will vary, the treatment approach and focus of treatment and systemic treatments will also vary.

In situations where sexual behavior problems are the primary problem, research-supported, evidence-informed short-term CBT models should be considered. In comorbid cases where sexual behavior problems may be a secondary focus, using well-supported, evidence-based treatments matched to the highest-priority comorbid problem combined with sexual behavior problem-focused components should be considered. For example, when children with sexual behavior problems suffer primarily from serious trauma symptoms, evidence-based trauma-focused treatment may be considered, combined with additional sexual behavior problem components addressing necessary environmental changes, supervision, and self-control strategies (Allen, 2018). When the sexual behavior problems are one element of a broad, overall pattern of early childhood disruptive behavior, well-supported models to address the overall pattern of disruptive behavior might be considered, combined with relevant sexual behavior problem-specific treatment components (Shawler, 2018). When the primary problem is a family/home situation or environment that is chaotic or in which neglect is present, treatment focused on creating a safe, healthy, stable, and predictable environment may be the top priority. When insecure attachment is a major concern, short-term treatment emphasizing parental sensitivity have been found to be the most effective (Bakermans-Kranenburg et al., 2003).

Addressing a child's needs often involves more than one focus area of treatment. Treatment that incorporates research-informed, evidence-based treatments into a single integrated treatment plan for a child with multiple problems is preferable to separate treatments. Often, there is overlap in the areas of focus of the treatment models for comorbid problems and treatments for sexual behavior problems. The treatment models for trauma and general behavior problems typically include components focused on emotional regulation, skill development, and parenting strategies and skills. This is consistent with treatments used when addressing sexual behavior problems. Providers need to combine and prioritize treatments to best address the needs of the individual child and their family.

A number of resources are available that provide information about evidence-based and empirically supported treatment models related to trauma, general behavior problems, or family environment situations. We encourage readers to review the literature and monitor various governmental and nongovernmental agencies that track this information. For United States clinicians, check the California Evidence-Based Clearinghouse for Child Welfare (CEBC) and/or Title IV-E Prevention Services Clearinghouse for identified evidence-based and empirically supported treatment models.

The term "children with sexual behavior problems" encompasses a range of problems, and therefore including descriptive language to clarify whether they are self-directed and/or interpersonal can be important. It is also important to recognize that the problems vary in their levels of intrusiveness and intensity, with some behaviors being overtly abusive.

Although different models or programs may use different terms, the broad focus areas of treatment typically include boundaries, impulse control, problem solving, coping skills, healthy emotional expression and emotional regulation skills, social skills and peer relationships, developmentally appropriate sex education, and sexual behavior rules. In addition, there is often a focus on the child recognizing that their behavior was inappropriate and the impact of their behavior on others. One approach to this involves apologies, while others may use an impact recognition approach. The terms and descriptions used also vary based on the age group. Individual needs and experiences, such as trauma, are also addressed as warranted and are incorporated into the treatment process. Not all children need all areas to be addressed with treatment.

Cognitive and social aspects of child development also have treatment implications. Young children's cognitive development limits their repertoire of coping strategies. For example, young children may touch their own genitals as a self-soothing behavior during times of stress (White et al., 1988).

This is far more common among younger children. Younger children may not yet have the ability to use more sophisticated cognitive coping strategies. Consequently, young children may need to be redirected to alternative coping mechanisms that are simple and concrete, rather than being taught cognitive coping strategies. Young children's cognitive development also limits the types of cognitive processes involved in initiating and maintaining sexual behavior problems. Children have shorter attention spans and more limited impulse control. In addition, their sexual behavior is more likely to be impulsive rather than compulsive, although some children, especially those who engage in self-directed sexual behavior, may present with some level of compulsiveness related to the behavior.

Children do not yet possess the cognitive maturity or emotion regulation that would allow them to use self-understanding to improve emotional and behavioral self-control. Rather, children's cognitive abilities are better suited to understanding simple rules about behavior.

For example, young children can be taught concrete rules about sexual behavior (e.g., "Don't touch other children's private parts"), and learn to follow these rules, even if they are unable to understand the more abstract reasons why the rule is necessary. Similarly, because young children learn better by demonstration, practice, and reinforcement, rather than by discussing abstract concepts, treatments may need to emphasize showing children appropriate behaviors such as boundaries, having them practice these behaviors, and consistently reinforcing the behaviors across settings.

Among older children (10-12 years old) with sexual behavior problems, some abstract principles along with basic rules may be included, but the levels of abstraction should be consistent with the child's level of developmental functioning.

The following list of treatment components for children with sexual behavior problems was compiled based on evidence from the literature, including components identified in studies about successful CBT programs. The list is intended to highlight components and focus areas and should not be viewed as all-inclusive. While some focus areas are appropriate for use with most children, not all children require all areas of focus. Areas addressed will be determined by their individual needs. Treatment components for children with sexual behavior problems and their caregivers may include the following:

- Learning basic sexual abuse prevention and safety skills.
- Learning and practicing simple rules about sexual behavior and physical boundaries based on the child's age and developmental functioning.
    -Cultural considerations may impact some rules commonly used (e.g., touching your own private parts while alone).

-Teaching sexual behavior and boundary rules should not imply that all forms of human sexuality, touching, or close physical contact are wrong and lead to trouble. It may be important to emphasize which behaviors are acceptable and distinguish them from behaviors that are against the rules.

- Developing coping and self-control strategies.
  - -This often includes a stop-and-think-before-acting strategy that can be used in a variety of situations including related to sexual behavior.
  - -This may include teaching relaxation skills, mindfulness, problem-solving skills, identifying motions, and managing emotions.
- Creating and implementing an age-appropriate and developmentally appropriate safety plan.
  - -The level of supervision and monitoring should fit the current individualized case assessment.
  - -This may include communicating with other adults (such as daycare personnel or extended family) about supervision needs; the level of communication is based on each individual case.
  - -Safety plans should be updated according to improvements in the child's behavior.
- Ensuring digital literacy and multimedia and technology safety.
  - -Appropriate safety measures may be installed to prevent accidental viewing or seeking of inappropriate material.
- Sharing information about sexual development and healthy sexual play and exploration, and explaining how they differ from sexual behavior problems.
- Developing and practicing appropriate social skills.
- For caregivers, teaching the child sex education and how to listen and talk with children about sexual matters.
- Focusing on parenting strategies to build positive relationships with children as well as prevent and respond to behavior problems. This component can include learning and practicing skills such as play skills, redirection, giving clear directions, use of labeled praise, use of time-out strategies and logical or natural consequences, and application of consistent rules and discipline.
- Supporting children's use of the self-control strategies they have learned.
- Building relationships and expressing appropriate physical affection with other children.
- Guiding the child toward positive peer groups.
- Focusing on the emotional quality of the parent–child relationship and enhancing supportive, positive, and mutually enjoyable interactions, if clinically warranted.
- Recognizing stress-related factors that the parents/caregivers may be experiencing, developing strategies to address them, and increasing support systems.
- Assisting parents/caregivers who may want or need to seek behavioral health services individually and helping them connect with a provider.

Importance of Parent and Caregiver Involvement

The involvement of parents and caregivers is a necessary component of treatment when working with children with sexual behavior problems. Their involvement includes learning about child development (including sexual development), general behavior issues, age-appropriate sex education, strategies for preventing and addressing sexual behavior, increasing their comfort in addressing these issues, and helping their child be safe in the multimedia and technology world. Specific efforts need to be made to engage the parents/caregivers in the treatment process, not only because it supports their active involvement but also impacts their child's involvement in treatment.
Treatments must address the social ecology of the child and family. It is important to note that sexual behavior problems can be a symptom of other concerns including traumas in the child's life, and therefore the treatments must seek to address underlying issues as well as the presenting sexual behavior problems.

Evidence from both clinical and research literature emphasizes parent involvement in treatment (Johnson, 1989; Johnson, 2004; Silovsky et al., 2006). This includes biological parents, foster or kinship care parents, or other caregivers, with consideration given to both current caregivers and likely future caregivers.
In some cases, the home environment actively contributes to the development and/or maintenance of the child's sexual behavior problems.

In order to effectively intervene, the home environment should be stabilized and contributing factors managed. In other cases, the home environment may not have contributed to the problem, but the involvement of parents/caregivers in treatment is still crucial for providing support and for implementing day-to-day aspects of the treatment plan. The more effective child behavior problem treatments examined to date in the literature have included an active parent component. Some are primarily parent-focused or parent-mediated approaches, such as parent skills training, while others involve parents as partners in the treatment (Brestan & Eyberg, 1998; Deblinger & Heflin, 1996; Hembree-Kigin & McNeil, 1995).

In many cases, it may be appropriate for therapists to empower parents to work directly with surrogate parents, such as daycare staff, neighbors who care for children, or teachers. Therapists may be directly involved to assess, model, and support, which will need to be decided on a case-by-case basis. Such processes would require appropriate releases of information and agreement to involve others by the child's custodial parents/caregivers. In cases where the sexual behavior problems occur at school or in similar venues, therapists might consider visiting the setting, observing the child's behavior, and offering teachers and staff clear, concrete, and practical suggestions for supervision and behavior management techniques.

For example, young children with sexual behavior problems in a daycare setting might need to stay near the teacher during nap times, avoid being alone with other children in the bathroom or changing areas, and receive appropriate reinforcement for keeping their hands to themselves. Teachers and staff can be educated that sexual behavior problems are not uniquely difficult behaviors to correct, and that most children with sexual behavior problems will discontinue the behavior given appropriate guidance, structure, and help (Horton, 1996). Working with schools and daycares as part of the treatment team may prevent the child from being expelled from these settings, which could otherwise lead to disadvantages and additional family burden (Kenney, 2020). Engagement is the first part of any behavioral health treatment. For this reason, efforts should be made to intentionally develop strategies and approaches to help not only the child, but also to make the parents/caregivers feel welcome and comfortable in the treatment situation. Typically, the child is not present at sessions unless the parents/caregivers arrange for this to occur. They need to know they are part of the process and working together with clinicians to improve the situation and provide support. Motivational interviewing can be helpful in engaging families (Miller & Rollnick, 2013).

Understanding the Impact of Adverse Childhood Experiences

As previously discussed, it is known that childhood maltreatment and other adverse childhood experiences can be associated with impairment in emotion processing, behavioral inhibition, and attention. These have consequences for academic achievement, IQ, language-based learning, and memory (Hart & Rubia, 2012; Samuelson et al., 2010; Teicher & Samson, 2016).

Although not all children with sexual behavior problems have a history of trauma, neglect, or adverse childhood experiences, significant numbers of them do. Therefore, it is important to understand how the child's experiences may have affected their learning and problem-solving abilities, as well as self-regulation and social interactions. Understanding the potential impact of these experiences enables clinicians to adjust and adapt approaches and treatments to the individual child's learning and emotional needs.

Treatment and Intervention Approaches

Treatment may take place at the individual, family, and/or group level. We recognize that many of the studies cited earlier involved treatment in a group format, and that groups are often discussed when talking about treatment for children with sexual behavior problems. However, that should not be interpreted to mean that the group format is necessarily preferred or that individual work is not valuable.

Although the group format can offer distinct advantages, it can also pose challenges. Clear practical advantages of the group approach are its low cost per unit of service and the practitioner being able to provide services to several children at the same time. Possible clinical benefits include the opportunity for vicarious learning, a reduced sense of isolation, and any benefits arising from a positive peer culture established within the group. Groups can spur interaction and discussion among children, offer the opportunity to observe live social interactions, and provide a place to practice new social skills. Group formats described in clinical and research literature have not segregated children with sexual behavior problems by gender and can accommodate all genders of comparable ages.

A therapist's use of effective behavior management strategies is critical to the success of a group approach. Without this, there may be unintended negative effects as a result of grouping together children with behavior problems, such as negative social models or peer reinforcement of negative behavior. Group approaches may not be the best fit for all children, including those with serious behavior problems, complicated comorbid issues, or high levels of anxiety. Group approaches require significant agency or provider effort to develop, and maintain.

They also require a sizable and consistent referral flow to maintain a consistent group size. Groups also pose complicated confidentiality issues. Supplemental family or individual sessions may be needed to address idiosyncratic or comorbid issues. In addition, groups may be difficult to establish in rural communities or in practices that receive fewer referrals. A group approach is not the only option for effective treatment.

Individual work with a child can be an appropriate and effective approach, depending on the child's circumstances, such as the nature of their living environment, trauma history, and developmental history. The needed focus areas of treatment can be addressed in this format and at times individual work allows for easier adjustment of the approach to fit the child. Practitioners must be prepared to be actively involved in role-play scenarios or acting out the practice of skills in the absence of other children. The child may also participate in individual family sessions with their parents/caregivers who can take an active role in helping the child practice skills.

Groups for parents and caregivers are also valuable in many ways. For example, groups can provide them with a sense of not being alone and recognizing that others are struggling with the same issues (Shields et al., 2018). They also provide an opportunity for parents/caregivers to learn together and support one another. Despite the value of these groups, it should be recognized that some parents/caregivers may be hesitant to participate in a group where others will know that their child is receiving treatment for sexual behavior problems.

They may be embarrassed or not trust others to keep the information confident outside the group. Concerns of this type may be particularly salient in small towns or communities where everyone tends to know one another.

Individual sessions can involve parents/caregivers and have them work directly with their child. The same content can be explored in these individual sessions as would be presented in a group format. In some cases, individual family sessions are necessary due to the specifics of the case and needs of the parents/caregivers.

It is important to keep in mind that identifying symptoms as part of the assessment drive the treatment that is delivered. If no symptoms are identified, then trauma or sexual behavior problems likely do not need to be treated or the child can be provided with appropriate education.

Research has shown that providing treatment options and interventions for children with sexual behavior problems can be effective. Important considerations include the following:

- Treatment typically involves cognitive-behavioral therapy approaches in individual, group, or family therapy modalities.
- Some children have been abused, neglected, or have a history of adverse childhood experiences, but not all children with sexual behavior problems have had these experiences.
- Treatment should be tailored to meet the needs of each individual child.
- Treatment approaches should be informed by the assessment, which not only provides information for effective treatment but also helps monitor progress.
- Parents and caregivers play a critical role in treatment and practitioners need to work with them in a collaborative manner.

SECTION 4: Decisions Related to Placement

Children with sexual behavior problems do not require automatic out-of-home placement, even children who have been abused by another child in the same home. Placement decisions require careful case-by-case assessment. Sustaining all children in their homes, families, and communities should always be the first option considered.

However, out-of-home placement may be necessary if retaining children in the home is not viable because it would cause harm or significant distress to other children, because of acute needs for treatment, safety, or protection, or because caregivers are not providing a safe and adequate environment. If out-of-home placement is required, priority should be given to the least restrictive setting that is closest to the child's home, and where families can remain involved in treatment.

The placement setting needs to ensure the safety of the child as well as others. Policies concerning the removal and placement of children should consider the impact on all children affected and strive to balance their respective interests. For example, residential placement may meet several needs for some children with sexual behavior problems, but it can also carry distinct disadvantages. Similarly, removing some children with sexual behavior problems may offer benefits to other children in the home, but in other instances may actually increase their distress.

The majority of cases do not involve these conditions. Many children with sexual behavior problems targeted at other children in their home do not require removal, either for their own welfare or the welfare of the other children. However, where the circumstances described above exist, action is warranted. Removal and placement may also be advisable for reasons other than sexual behavior problems, for example, due to maltreatment by caretakers in the home or due to comorbid problems. Some families may opt to place a child out of their home to a relative's home for the sake of convenience or to reduce stress within the family.

In cases where it is not immediately clear whether removal is warranted, short-term removal pending further assessment can be considered. In these cases, assessment and decision making should be expedited to minimize the duration of the temporary placement. Where out-of-home placement is involved, less restrictive alternatives, such as placement with extended family or therapeutic foster care, should be considered first. Placement in a residential facility, particularly facilities that focus on children with behavior problems, may be necessary in a limited number of cases due to clear safety issues and/or severity of mental health issues that cannot be adequately addressed in a less restrictive environment. Such placements need to be carefully considered and viewed as a last option. When residential placement is necessary, the child's progress needs to be carefully monitored to support the child moving to a less restrictive environment as soon as safety and mental health functioning permit.

When a child with sexual behavior problems is placed in out-of-home care, questions arise as to whether the child can be placed with other children in a foster home, community congregate care setting, or residential facility. The child may need to be segregated away from other children in foster care, placed in a special segregated home, or housed in a special segregated residential sexual behavior problem program.

If any child's behavior is out of control or poses an acute and substantial risk for serious harm to themselves or other children, a more restrictive and segregated environment is warranted. Fear of liability exposure may lead some facilities to establish policies that segregate all children labeled as having sexual behavior problems, regardless of whether a safety concern exists, which reinforces the need for accurate, specialized assessments.

A sensitive, developmentally appropriate plan for reducing the risk of harmful sexual behavior among all children should be considered within all placements. Although children known to have sexual behavior problems require additional monitoring and attention in this area, experience suggests that the level of monitoring and attention required is often well within the capability of general placements.

Many general and residential facilities have successfully accommodated children with these types of behavior problems in their general population. Considering placement of a child with a sexual behavior problem in another home setting with other children raises questions and concerns that would need to be addressed prior to making such a decision. This includes considering why the child was removed from their own home, the history of sexual behavior problems, current sexual behavior problems, ages of other children in the home, vulnerabilities of others in the home, and other considerations related to safety including necessary precautions.

Accommodating children with sexual behavior problems within general facilities involves common-sense precautions. For example, a child with a sexual behavior problem may need to have a separate bedroom and not bathe or change their clothing around other children. Children with sexual behavior problems may also need adult monitoring when interacting with other children, which is not unusual for children in placement. In addition, selection of appropriate entertainment material and monitoring internet use may be necessary. Wrestling, tickling, or similar behaviors may need to be discouraged. Such common-sense precautions are often sufficient for children with sexual behavior problems who are in placement and are well within the capabilities of most facilities.

The needs and best interests of children with sexual behavior problems also must be considered in decisions about segregation. In general, foster homes, agencies, and facilities should be discouraged from developing policies that exclude children with sexual behavior problems, as a group, from their services.
The idea that children with sexual behavior problems must be placed only in segregated sexual behavior problem facilities may exclude them from needed services and impose unnecessary placement and service disadvantages. It also may needlessly label and stigmatize the children.

Such policies are especially problematic when children are excluded from services based on long-past history of sexual behavior problems that have not reoccurred. We believe the best policy is for children with sexual behavior problems to have the same open access to all needed placements and services as all other children.

Excluding children from placements or services due to sexual behavior problems can only increase the likelihood of developing additional problems and experiencing unnecessary disadvantages.

Information Sharing

Sharing relevant information between treatment and care providers is vital, but confidentiality must be maintained. Only the team of professionals responsible for treating the children should have access to shared information. When sharing information about a child's sexual behavior problems with foster or kinship parents, it is important to approach the topic sensitively, without judgment and in a matter-of-fact manner.

If a child is placed in a home with other children, it may be wise to discuss a safety plan for all youth in the home. A safety plan should ensure proper supervision while allowing for as much normalcy as possible in the home. Most children with sexual behavior problems can and should attend school with other children, unless their behavior is unusually severe and unmanageable. When children with sexual behavior problems attend school with other children, the concern arises regarding who should be informed, if anyone, at the school. As with other questions, a policy of individualized, assessment-driven decision making is suggested. Notifying schools about all cases of sexual behavior problems is unnecessary, especially if the problem has not previously occurred in school settings, the child is receiving help for the problem, and the behavior is not persisting.

However, if an assessment shows that a child has likely demonstrated the behavior at school, that sexual behavior problems have occurred in school or school-like settings, or that serious sexual behavior problems are persisting, it would be appropriate to inform school personnel. Often, parents or caregivers may provide helpful input about who at the school would be best to approach. Teachers or school administrators may have little factual information about children with sexual behavior problems or may have been exposed to misinformation. Consequently, it may be necessary to provide accurate information along with practical common-sense recommendations.

Interagency Collaboration

Collaboration among involved agencies, authorities, and providers is necessary during all phases of working with children who have sexual behavior problems. As such, we recommend that policies be developed that allow and promote collaboration. This is a general good practice principle, not limited to children with sexual behavior problems. Collaborations can include treatment providers, child welfare workers, parents, foster parents, schools, childcare providers, law enforcement, medical care providers, child advocates, juvenile justice staff, and courts. The extent of collaboration and who may need to be included may vary considerably depending on the needs and experiences of the child. Collaboration should follow all applicable laws, policies, and ethical principles governing information sharing. This includes obtaining voluntary authorizations for sharing protected health information, executing any necessary data use or collaboration agreements among teams of collaborators (e.g., confidentiality agreements among multiple party planning or coordination groups), and maintaining appropriate records of what information is shared and with whom.

Information regarding the safety of the child and other children, current and planned services, and overall treatment progress is shared among treatment provider teams to ensure that services are coordinated and evaluated, and that duplicated or incompatible services and actions are avoided. In complex cases where multiple service systems are involved, it may be useful for a coordinator or case manager to organize collaborative efforts. Systems of care or similar formal structures in place in many communities may be useful in complex cases where multiple agencies are involved (HHS, 1999).

The main purpose of coordination and information sharing is to define consensus goals, articulate a clear plan and timetable of specific tasks needed to reach those goals, identify who will be responsible for each aspect of the plan, and evaluate plan implementation and goal attainment.

Children with sexual behavior problems do not require automatic out-of-home placement, even children who have been abused by another child in the same home. Placement decisions require careful case-by-case assessment.

- Policies concerning the removal and placement of children should consider the impact on all children affected and strive to balance their respective interests.
- A sensitive, developmentally appropriate plan for reducing the risk of harmful sexual behavior among all children should be considered within all placements *(continued)*.
- A sensitive, developmentally appropriate plan for reducing the risk of harmful sexual behavior among all children should be considered within all placements.
- Sharing relevant information between treatment and care providers is vital, but confidentiality must be maintained.
- Information regarding the safety of the child and other children, current and planned services, and overall treatment progress is shared among treatment provider teams to ensure that services are coordinated and evaluated, and that duplicated or incompatible services and actions are avoided.

Conclusion

The positions articulated in this report are intended to serve as suggested practices and recommendations. The committee strived to ground these in the best available scientific research, general good practice principles, and accepted ethical codes. As with any report, we believe the suggestions and recommendations outlined in the report should be given due consideration by practitioners and policy makers, but should not be confused with formal practice standards.

References

Allen, B. (2017). Children with sexual behavior problems: Clinical characteristics and relationship to child maltreatment. Child Psychiatry and 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 Behaviors. Cognitive and Behavioral Practice 2018 Pages 240-249.
https://doi: https://doi.org/10.1016/j.cbpra.2017.07.001

Allen, B., Thorn, B. L., & Gully, K. J. (2015). A comparison of self-reported emotional and trauma-related concerns among sexually abused children with and without sexual behavior problems. Child Maltreatment, 20(2), 136–140.
https://doi.org/10.1177/1077559514566864

Araji, S. K. (1997). Sexually aggressive children: Coming to understand them. Sage Publications.

Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., & Juffer, F. (2003). Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. Psychological Bulletin, 129(2), 195–215.
https://doi.org/10.1037/0033-2909.129.2.195

Bonner, B. L., Walker, C. E., Berliner, L., Bard, D. & Silovsky, J. F. (2005). [Cluster analyses of children with sexual behavior problems]. Unpublished data.

Bonner, B. L., Walker, C. E., & Berliner, L. (1999). Children with sexual behavior problems: Assessment and treatment-final report. Grant No. 90-CA-1469. U. S. Department of Health and Human Services, National Clearinghouse on Child Abuse and Neglect.

Brestan, E. V., & Eyberg, S. M. (1998). Effective psychosocial treatments of conduct-disordered children and adolescents: 29 years, 82 studies, and 5,272 kids. Journal of Clinical Child Psychology, 27(2), 180–189.
https://doi.org/10.1207/s15374424jccp2702_5

British Columbia Ministry of Education (1999). Responding to children's problem sexual behaviour in elementary schools: A resource for educators. Authors.

Campbell, C., Heidari, Z., Whitworth, D., Lajos, J., & Silovsky, J. F. (2012). Gender differences in sexual behavior problems for preschool children. Presented at the 31st Conference of the Association for the Treatment of Sexual Abusers. Denver, CO.

Chaffin, M. (2006). The changing focus of child maltreatment research and practice within psychology. The Journal of Social Issues, 62(4), 663–684. https://doi.org/10.1111/j.1540-4560.2006.00482.x

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., 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. Jenny, T. Hendrix, C. Jenny, & T. E. Reid (Eds.), The APSAC handbook on child maltreatment (2nd ed., pp. 205–232). Sage Publications.

Chouinard-Thivierge, S., Lussier, P., & Daignault, I. V. (2022). A longitudinal examination of developmental covariates of sexual behavior problems among youth referred to child protection services. Sexual Abuse, 34(5), 537–567. https://doi.org/10.1177/10790632211047184

Deblinger, E., & Heflin, A. H. (1996). Treating sexually abused children and their nonoffending parents. Thousand Oaks, CA: Sage Publications.

DeLago, C., Schroeder, C. M., Cooper, B., Deblinger, E., Dudek, E., Yu, R., & Finkel, M. A. (2020). Children who engaged in interpersonal problematic sexual behaviors. Child Abuse & Neglect, 105, 104260. https://doi.org/10.1016/j.chiabu.2019.104260

Dillard, R., Maguire-Jack, K., Showalter, K., Wolf, K. G., & Letson, M. M. (2019). Abuse disclosures of youth with problem sexualized behaviors and trauma symptomology. Child Abuse & Neglect, 88, 201–211. https://doi.org/10.1016/j.chiabu.2018.11.019

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

Ensink, K., Godbout, N., Bigras, N., Lampron, J., Sabourin, S., & Normandin, L. (2018). Persistent and transitory sexualized behavior problems in children. Child Psychiatry and Human Development, 49(4):621¬–631. https://doi.org/10.1007/s10578-017-0778-0

Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. Child Abuse & Neglect, 36(2), 156¬–165.
https://doi.org/10.1016/j.chiabu.2011.10.006

Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). Juveniles who commit sex offenses against minors. U.S. Department of Justice, Juvenile Justice Bulletin. Retrieved from http://www.ojp.usdoj.gov

Friedrich, W. N. (2002). Psychological assessment of sexually abused children and their families. Sage Publications.
https://doi.org/10.4135/9781452233192

Friedrich, W. N., & Luecke, W. J. (1988). Young school-age sexually aggressive children. Professional Psychology, Research and Practice, 19(2), 155–164.
https://doi.org/10.1037/0735-7028.19.2.155

Friedrich, W. N., Davies, W. H., Feher, E., & Wright, J. (2003). Sexual behavior problems in preteen children: Developmental, ecological, and behavioral correlates. Annals of the New York Academy of Sciences, 989(1), 95–104.
https://doi.org/10.1111/j.1749-6632.2003.tb07296.x

Friedrich, W. N., Trane, S. T., & Gully, K. J. (2005). Letter to the Editor: Re: It is a mistake to conclude that sexual abuse and sexualized behavior are not related: A reply to Drach, Wientzen, and Ricci (2001). Child Abuse & Neglect, 29, 297–302.
Friedrich, W. N. (1993). Sexual victimization and sexual behavior in children: A review of recent literature. Child Abuse & Neglect, 17(1), 59–66.
https://doi.org/10.1016/0145-2134(93)90008-S

Friedrich, W. N., Fisher, J. L., Dittner, C. A., Acton, R., Berliner, L., Butler, J., Damon, L., Davies, W. H., Gray, A., & Wright, J. (2001). Child Sexual Behavior Inventory: Normative, psychiatric, and sexual abuse comparisons. Child Maltreatment, 6, 37–49.
https://doi.org/10.1177/1077559501006001004

Friedrich, W. N., Sandfort, T. G., Oostveen, J., & Cohen-Kettenis, P. T. (2000). Cultural differences in sexual behavior: 2–6-year-old Dutch and American children. Journal of Psychology & Human Sexuality, 12(1-2), 117–129.
https://doi.org/10.1300/J056v12n01_08

Gewirtz-Meydan, A., Lahav, Y., Walsh, W., & Finkelhor, D. (2019). Psychopathology among adult survivors of child pornography. Child Abuse & Neglect, 98, 104189. https://doi.org/10.1016/j.chiabu.2019.104189

Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. Lancet, 373(9657), 68–81. https://doi.org/10.1016/S0140-6736(08)61706-7

Gray, A., Pithers, W. D., Busconi, A., & Houchens, P. (1999). Developmental and etiological characteristics of children with sexual behavior problems: Treatment implications. Child Abuse & Neglect, 23(6), 601–621. https://doi.org/10.1016/S0145-2134(99)00027-7

Grossi, L. M., Brereton, A., Lee, A. F., Schuler, A., & Prentky, R. A. (2017). Sexual reoffense trajectories with youths in the child welfare system. Child Abuse & Neglect, 68, 81–95. https://doi.org/10.1016/j.chiabu.2017.03.024

Hackett, S. (2014). Children and young people with harmful sexual behaviours. Dartington: Research in Practice.

Hackett, S., Phillips, J., Masson, H., & Balfe, M. (2013). Individual, family and abuse characteristics of 700 British child and adolescent sexual abusers. Child Abuse Review, 22(4), 232¬–245. http://dx.doi.org/10.1002/car.2246

Hall, D. K., Mathews, F., & Pearce, J. (1998). Factors associated with sexual behavior problems in young sexually abused children. Child Abuse & Neglect, 22(10), 1045–1063.
Hall, D., Mathews, F., Pearce, J., Sarlo-McGarvey, N., & Gavin, D. (1996). The development of sexual behavior problems. Author.

Hart, H., & Rubia, K. (2012). Neuroimaging of child abuse: A critical review. Frontiers in Human Neuroscience, 6, 52. https://doi.org/10.3389/fnhum.2012.00052
Heiman, M. L., Leiblum, S., Cohen Esquilin, S., & Melendez Pallitto, L. (1998). A comparative survey of beliefs about “normal” childhood sexual behaviors. Child Abuse & Neglect, 22(4), 289–304. https://doi.org/10.1016/S0145-2134(97)00176-2

Hembree-Kigin, T. L., & McNeil, C. (1995). Parent-child interaction therapy. Plenum Press. https://doi.org/10.1007/978-1-4899-1439-2

Hewitt, S. K. (1999). Assessing allegation of sexual abuse in preschool children: Understanding small voices. Interpersonal Violence: The Practice Series. Sage Publications.

Horton, C. B. (1996). Children who molest other children: The school psychologist's response to the sexually aggressive child. School Psychology Review, 25(4), 540–557. https://doi.org/10.1080/02796015.1996.12085843

Johnson, T. C. (2004). Helping children with sexual behavior problems - A guidebook for parents and substitute caregivers (2nd ed.). Author.

Johnson, T. C. (1988). Child perpetrators—children who molest other children: Preliminary findings. Child Abuse & Neglect, 12(2), 219–229. https://doi.org/10.1016/0145-2134(88)90030-0

Johnson, T. C. (1989). Female child perpetrators: Children who molest other children. Child Abuse & Neglect, 13(4), 571–585. https://doi.org/10.1016/0145-2134(89)90061-6

Johnson, T. C. (2015). Understanding children's sexual behaviors: What is natural and healthy. Safer Society Press.

Junghans, A., Jaquez, S., Campbell, C., & Silovsky, J. F. (2012). Exposure to a sexualized environment and child sexual behavior problems [Conference poster]. Association of Cognitive Behavioral Therapists Annual Meeting, National Harbor, MD.

Kendall-Tackett, K. A., Williams, L. M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. Psychological Bulletin, 113(1), 164–180. https://doi.org/10.1037/0033-2909.113.1.164

Kenney, J. W. (2020). Problematic sexual behaviors in schools (2nd ed). Rowman & Littlefield.

Letourneau, E. J., Brown, D. S., Fang, X., Hassan, A., & Mercy, J. A. (2018). The economic burden of child sexual abuse in the United States. Child Abuse & Neglect, 79, 413–422. https://doi.org/10.1016/j.chiabu.2018.02.020

Lévesque, M., Bigras, M., & Pauzé, R. (2012). Persistence of problematic sexual behaviors in children. Journal of Clinical Child and Adolescent Psychology, 41(2), 239–245.
https://doi.org/10.1080/15374416.2012.651991

Loeber, R., Burke, J. D., Lahey, B. B., Winters, A., & Zera, M. (2000). Oppositional defiant and conduct disorder: A review of the past 10 years, part I. Journal of the American Academy of Child and Adolescent Psychiatry, 39(12), 1468–1484.
https://doi.org/10.1097/00004583-200012000-00007

Lussier, P., & Healey, J. (2010). Searching for the developmental origins of sexual violence: Examining the co-occurrence of physical aggression and sexual behaviors in early childhood. Behavioral Sciences & the Law, 28(1), 1–23.
https://doi.org/10.1002/bsl.919

Lussier, P., Chouinard-Thivierge, S., McCuish, E., Nadeau, D., & Lacerte, D. (2019). Early life adversities and polyvictimization in young persons with sexual behavior problems: A longitudinal study of child protective service referrals. Child Abuse & Neglect, 88, 37–50.
https://doi.org/10.1016/j.chiabu.2018.10.017

Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd ed.). Guilford Press.

Miragoli, S., Camisasca, E., & Di Blasio, P. (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

N'zi, A., Hunter, M., & Silovsky, J. F. (2017). Types and duration of out-of-home placement for preschool age children with problematic sexual behavior. Unpublished manuscript.

Pithers, W. D., Gray, A., Busconi, A., & Houchens, P. (1998). Children with sexual behavior problems: Identification of five distinct child types and related treatment considerations. Child Maltreatment, 3(4), 384–406.
https://doi.org/10.1177/1077559598003004010

Prentky, R. A., Li, N. C., Righthand, S., Schuler, A., Cavanaugh, D., & Lee, A. F. (2010). Assessing risk of sexually abusive behavior among youth in a child welfare sample. Behavioral Sciences & the Law, 28(1), 24–45.
https://doi.org/10.1002/bsl.920

Rasmussen, L. A. (1999). Factors related to recidivism among juvenile sexual offenders. Sexual Abuse, 11(1), 69–85.
https://doi.org/10.1177/107906329901100106

Rasmussen, L. A., Burton, J. E., & Christopherson, B. J. (1992). Precursors to offending and the trauma outcome process in sexually reactive children. Journal of Child Sexual Abuse, 1(1), 33–48.
https://doi.org/10.1300/J070v01n01_03

Samuelson, K. W., Krueger, C. E., Burnett, C., & Wilson, C. K. (2010). Neuropsychological functioning in children with posttraumatic stress disorder. Child Neuropsychology, 16(2), 119–133.
https://doi.org/10.1080/09297040903190782

Shawler, P.M., Bard, M.E., Taylor, E. K., Wilsie, C. Funderburk, B. and 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 2018 Vol. 84 Pages 206-214.
https://doi.org/10.1016/j.childyouth.2017.12.006

Shields, J. D., Klinkebiel, C. M., Taylor, E. K., Espeleta, H. C., Beasley, L. O., & Silovsky, J. F. (2018). A qualitative analysis of family perspective on treatment services for youth with problematic sexual behavior. Victims & Offenders, 13(7), 955–973.
https://doi.org/10.1080/15564886.2018.1506853

Silovsky, J., & Bonner, B. L. (2003). Sexual behavior problems. In T. H. Ollendick & C. S. Schroeder (Eds.), Encyclopedia of Clinical Child and Pediatric Psychology. Kluwer Press.

Silovsky, J. (2009). Support for families with sexual behavior problems. The Safer Society Press. 5–23

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., Hunter, M. D., & Taylor, E. K. (2019). Impact of early intervention for youth with problematic sexual behaviors and their caregivers. Journal of Sexual Aggression, 25, 4–15.
https://doi.org/10.1080/13552600.2018.1507487

Silovsky, J. F., Letourneau, E. J., & Bonner, B. L. (2020). Introduction to CAN special issue: Children with problem sexual behavior. Child Abuse & Neglect, 105, 104508.
https://doi.org/10.1016/j.chiabu.2020.104508

Silovsky, J. F., Swisher, L. M., Widdifield, J., Jr., & Burris, L. (2011). Clinical considerations when children have problematic sexual behavior. In Goodyear-Brown, P. (Ed.), Handbook of child sexual abuse: Identification, assessment, and treatment (pp. 399–428). John Wiley & Sons, Inc.
https://doi.org/10.1002/9781118094822.ch18

Silovsky, J. F., Niec, L., Bard, D., & Hecht, D. (2006). Treatment for preschool children with sexual behavior problems: Pilot study. Unpublished manuscript.

Smith, T. J., Lindsey, R. A., Bohora, S., & Silovsky, J. F. (2019). Predictors of intrusive sexual behaviors in preschool-aged children. The Journal of Sex Research, 56(2), 229–238.
https://doi.org/10.1080/00224499.2018.1447639

Substance Abuse and Mental Health Services Administration (SAMHSA). (2011). Helping children and youth who have experienced traumatic events. Retrieved from:
http://rems.ed.gov/docs/repository/00000357.pdf

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

Teicher, M. H., & Samson, J. A. (2016). Annual Research Review: Enduring neurobiological effects of childhood abuse and neglect. Journal of Child Psychology and Psychiatry, and Allied Disciplines, 57(3), 241–266.
https://doi.org/10.1111/jcpp.12507

U.S. Department of Health and Human Services (HHS). (1999). Mental Health: A Report of the Surgeon General. U.S. Government Printing Office.

Wamser-Nanney, R., & Campbell, C. L. (2019). Children's sexual behavior problems: An ecological model using the LONGSCAN data. Child Abuse & Neglect, 96, 104085.
https://doi.org/10.1016/j.chiabu.2019.104085

White, S., Halpin, B. M., Strom, G. A., & Santilli, G. (1988). Behavioral comparisons of young sexually abused, neglected, and nonreferred children. Journal of Clinical Child Psychology, 17(1), 53–58.
https://doi.org/10.1207/s15374424jccp1701_7