Sex Offender Management Board
Office of Domestic Violence & Sex Offender Management
700 Kipling, Suite 3000 • Lakewood, CO 80215 • 303.239.4442

Children with Problematic Sexual Behavior Resource Document
Colorado Sex Offender Management Board
Best Practices Committee/Children with Problematic Sexual Behavior Sub-Committee
Approved February 17, 2023

Definition

This Resource Document will refer to the target population as children with problematic sexual behavior (PSB). This definition refers to those children 12 years or age or under who have been involved in PSB, which is more explained in the Document below and is also sometimes referred to as sexual behavior problems (SBP).

Introduction

The Colorado Sex Offender Management Board (SOMB) has convened a Sub-Committee of the Best Practices Committee to review issues related to children with problematic sexual behavior (PSB). This population encompasses children 12 years old and under who have been involved in PSB that has led to adjudication for those ages 10-12, involvement of the Department of Human Services, and/or identification through the school system. The purpose of this resource document is to provide guidance to treatment providers and other professionals working on these cases in terms of the characteristics and dynamics of children with PSB and the risk they pose for future sexual offending behavior. Providing resources and best practice interventions to prevent future offending is seen as the role of the members of the SOMB. The SOMB has purview over youth adjudicated for sexual crimes, but not those who are identified through non-court based mechanisms. This resource document will identify best practice interventions that can be used in any circumstances with children with PSB.

History of the problem and how to respond to children with problematic sexual behavior

Gail Ryan reminds that childhood sexual behavior is not a pathological condition. Children exhibit a broad range of sexual behaviors from curious exploration of others to sexually aggressive behaviors (as cited in Ryan, 2010). Cavanaugh-Johnson, Ryan, and others have sought to differentiate this range to assist individuals and systems in evaluating and responding to childhood sexual behaviors. The full range of sexual behaviors of children falls along a continuum including typical, non-typical normal, problematic, and abusive behavior (Cavanaugh-Johnson; as cited in Ryan, 2010).

The decades leading up to the year 2000 saw an increase in the number of children with problematic sexual behavior (PSB) who were referred for child protective services, juvenile

services, and treatment in both outpatient and inpatient settings (as cited in Gray et al, 1999). It was not known whether this represented an increase in the incidence of these behaviors, changing definitions of PSB, increased awareness and reporting, or some combination of these factors. Theoretical frameworks about the etiology of Childhood PSB were focused primarily on the role of sexual victimization. Clinical studies on the effects of child sexual abuse led to further research on childhood and adolescent PSB, defined as behaviors that are developmentally inappropriate, repetitive, intrusive, coercive, and/or aggressive (Friedrich et al., 1991; Chaffin et al., 2000; Lussier et al., 2017; Pithers et al., 1998).

High percentages of children with PSB have been found to have histories of sexual abuse (Allen, Thorn, & Gully, 2015; Friedrich, 1988; Johnson, 1988,1989; Tarren-Sweeney, 2008). Studies have also found that 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, Trane & Gully, 2005; Kendall-Tackett, Williams, & Finkelhor, 1993). While sexual victimization is a developmental antecedent for some, the developmental history of children with PSB as a whole is more complex and extremely diverse (e.g., Lussier et al., 2019; Wanklyn et al., 2012). Numerous studies have found that children with PSB have experienced multiple instances of adversity. Various familial, contextual, and individual factors have been correlated with PSB in childhood and adolescence (Bladon et al., 2005; Gray et al., 1997; Hall et al., 2018; Leon et al., 2008; Letourneau et al., 2004; Lussier et al., 2019; Merrick et al., 2008; Szanto et al., 2012; Wieckowski et al., 1998).

Finally, Chouinard Thivierge et al (2022) and others argue that it is clear that Adverse Childhood Experiences (ACEs) are a key component of any model that attempts to explain childhood PSB and its continuity into adolescence. Research is increasingly supporting a developmental approach to understanding the origin and development of PSB that explores a broader range of adversities in early life and nonsexual behavior problems (Chaffin et al., 2000; Elkovitch et al., 2009; Lussier, 2017). Both trauma and further developmentally informed research is needed to understand the factors involved in the development of and interventions for Children with PSB (Lussier, et al, 2022)

Identification of children with problematic sexual behavior

Children with problematic sexual behavior come to the attention of county departments of human/social services through reports to the child abuse hotline or through the juvenile justice system. Child welfare agencies are only involved with intrafamilial sexual abuse so third-party allegations are usually screened out and reported to law enforcement to investigate if it meets criteria for criminal investigation. If the child is under 10, there is no law enforcement involvement as no charges can currently be filed. In these instances, the child welfare agency will assess the allegations and intervene in the least restrictive manner to assist with providing

safety to the victim and treatment for both of the children and family members. If a youth over 10 years old is charged with an intrafamilial sexual abuse, the child welfare agency may intervene as well to provide services and supports if the juvenile court makes a referral to the county department of human/social services. If there is a determination made by the court that a family does need human/social services intervention, then a treatment plan will be developed for all members of both families to address safety concerns and treatment needs. Families can also agree to work with the county department of human/social services on a non-court involved case for services and supports.

Colorado child welfare data from January of 2020 through May of 2022 indicate that there were 307 unique referrals for sexual abuse with a person responsible for abuse under age 13. Those referrals include 339 unique victims and 298 unique persons responsible for abuse. The severity level of sexual abuse in 83% of those referrals was minor, 15% was moderate, and 2% was severe. Sexual abuse severity is determined based upon the type of contact, duration of contact, and the emotional impact upon the child.

Colorado adjudication data

Information was compiled by the Colorado District Attorney's Council from all 22 judicial districts in Colorado for children ages 10-12 adjudicated between 2011 and 2021 on 1,501 juvenile cases for one of the following sex crimes:

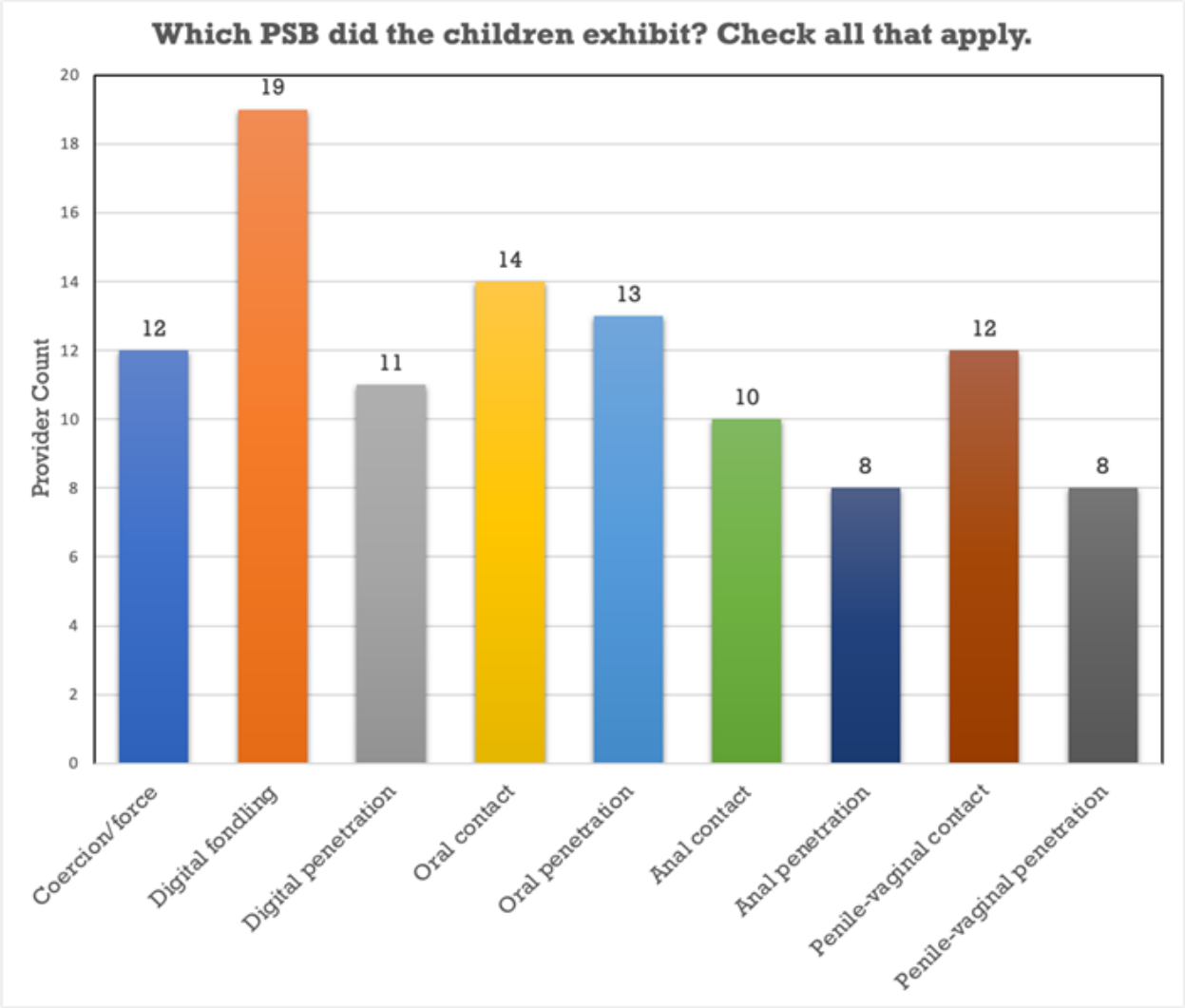
- 223 cases (15%) for Incest including Incest (C.R.S. 18-6-301), and Aggravated Incest (C.R.S. 18-6-302)
- 819 cases (55%) for Sexual Assault on a Child including Sexual Assault on a Child (C.R.S. 18-3-405), Sexual Assault on a Child by One in Position of Trust (C.R.S. 18-3-405.3), and Sexual Assault on a Child - Pattern of Abuse (C.R.S. 18-3-405.3(2)(b))
- 331 cases (22%) for Unlawful Sexual Contact (C.R.S. 18-3-404)
- 128 cases (8%) for Sexual Assault (C.R.S. 18-3-402)

SOMB juvenile provider, children with problematic sexual behavior survey

The SOMB surveyed SOMB Approved Juvenile Providers in November 2022 to assess the numbers working with children with problematic sexual behavior (PSB) and the characteristics of those children. The survey was responded to by 35 SOMB Juvenile Providers, with 23 reporting they had provided services to children with PSB, ages 4-12, during the last three years. The total response rate represented just over 20% of all SOMB Juvenile Providers and indicated that, at minimum, 14% of SOMB Juvenile Providers have worked with children with PSB. Approximately half of the SOMB Juvenile Providers reported having 1-5 clients, 20% reported having 6-10 clients, and 30% reported having more than 10 clients. At a minimum, this represents at least 118 children under 12 with PSB referrals in Colorado over the last 3 years.

Most Providers received referrals from Human Services, while about half received referrals from Diversion, Probation, and Parent Caregivers. A few Providers received referrals from schools. Most Providers indicated that 25% or less of the children with PSB were adjudicated.

Based on the survey responses, it was apparent that most of the children with PSB were 9-12 years of age, with a small proportion being 5-8 years, and at least one child client being younger. The most common gender was male, rather than female, transgender, or non-binary. The children with PSB were from all racial/ethnic identities. Most Providers treated children with PSB who were White, while over half also had children who were Hispanic and African American. The range of PSB exhibited was extensive, as shown in the chart below. Most children with PSB acted out sexually with one child, while some acted out sexually with 2-3 children. Most Providers treated children with PSB who acted against children ages 5-8 years, while about half had children who acted against children from birth to 4 years and 9-12 years. The gender of the child experiencing the PSB was most commonly female, although many Providers had children with PSB who acted out with male children also. Most children with PSB acted out sexually with other children in the home setting, including siblings, step siblings, and cousins, although some Providers had children who acted against school peers and neighbors. Most Providers indicated that 25-75% of the children with PSB were themselves victims of sexual abuse.



Sexual development

Sexual development is a natural and expected part of human development. Beginning even before birth the human body is capable of experiencing sexual arousal, spontaneously and in response to stimulation of the genitals. Sexual development is broader than reproduction and encompasses various aspects of sexuality and sexual identity. Although sexual behavior is typical it does not mean it should be ignored. It is important to know what behavior is to be expected and what behavior warrants additional attention. Sexual behavior looks different at various stages of development and generally progresses in complexity as children mature. Behavior at younger ages is generally simplistic and exploratory in nature while behavior in older children is more complex and pleasure driven.

During the early years between birth to age 6 typical sexual development involves:

- Having questions and seeking information about differences in gender and body parts. Children as young as 3 can identify their own gender and not long after can identify the genders of others.
- Beginning to understand the concept of pregnancy and birth and know that babies grow in their mother's womb.
- Exploration of genitals and pleasure. Children are curious about sexuality and tend to learn by listening, watching, touching, and imitating. It is common for children between two and five to look at others' bodies and be curious, especially if they are naked.
- Sexual play begins, typically in "I'll show you mine if you show me yours" type games.

Atypical behaviors during the birth to age 6 age range include:

- Possessing information about specific sexual acts or explicit sexual language.
- Engaging in adult-like sexual behavior with other children, or planned or aggressive sexual behavior. It is also not typical for children this age to insert objects into genitals, or pretend toys are having sex.

During the ages of 7-12 sexual development typically includes:

- Beginning to have questions and information about physical changes and development, relationships, and sexual behavior.
- Beginning to have body changes and start puberty. Girls typically begin menstruation between ages 9 and 15.
- Experimenting with same-age and same gender kids through games or role playing.
- Self-stimulation in a private setting is common and children begin to be more modest and reserved about their sexual behavior.
- Sexual knowledge increases with more questions about sexual material.
- Beginning to use sexual words and discussing sexual acts and personal values with peers.

Atypical behaviors during the 7-12 age range include:

- Adult-like sexual interactions
- Having knowledge of detailed sexual acts.
- Engaging in sexual behavior in public places.

During the ages of 13-16 sexual development typically includes:

- Beginning to have questions about decision making, social relationships, and sexual behavior.
- Children in this age group may engage in self-stimulation and sexual experimentation with peers of the same age.
- Voyeuristic behavior may occur and for about one-third of children this age their first sexual intercourse experience occurs.

Atypical behaviors during the 13-16 age range include:

- Sexual interest in younger children.
- Masturbation in public places.

Regardless of age, atypical sexual behavior in childhood including indicators of a sexual behavior problem occur when the sexual behavior:

- Causes harm to the child's bodies or another's body.
- Causes discomfort to one of the participants.
- Interferes with other aspects of life such as school, relationships, or home activities. This is also true with the viewing of sexually explicit or pornographic material that may interfere with aspects of daily life.
- Is inappropriately secretive.
- Violates rules.
- Occurs between children of widely different ages
- Occurs at a greater frequency or much earlier age than developmentally expected
- Continues after attempts to intervene or correct the behavior.

Regardless of age, sexual behavior that indicates sexual abuse includes;

- Lack of consent, lack of equality, and coercion.
    - Consent is impacted when there is a compromised ability to freely agree or disagree with the behavior without penalty or harm. This can be due to:
        - Differences in size, understanding, and emotional or cognitive maturity.
        - Popularity status.
        - Use of threats whether direct or implied.
        - Use of bribes, threats, pressure or force to engage in sexual behavior.
        - Impairment due to mind-altering substances or limited cognitive abilities.
        - Sexual behavior that violates law.

Within the context of sexual development, it is common for children to be exposed to sexually explicit material and pornography starting around the age of seven. While being exposed to such material is common, it should still be addressed due to the variety of explicit or pornographic material a young person may be exposed to or seek out. Sexually explicit or pornographic images are readily available via the internet and it is important to consider the nature of the images in the context of the child's age. Younger children tend to be exposed to or seek out material that depicts common sex acts as opposed to more graphic, fetish-based material. The level of intervention may vary depending on the type, frequency, complexity, and child's response to the sexually explicit or pornographic material.

Prevention and education strategies for school professionals working with children

School personnel are uniquely situated to prevent, mitigate, and report child sexual abuse. Nationally, up to 1 in 4 girls and 1 in 6 boys are victims of child sexual abuse (Finkelhor et al., 1990). School officials are significantly more likely than police to know about interpersonal violence occurring against students (Finkelhor et al., 2012). As the Adverse Childhood Experiences Study (ACEs) noted, childhood trauma can have negative lasting long-term effects on life expectancy, economic outlook, and life satisfaction (Felitti & Anda, 1997). Most child sexual abuse is committed by other children with children committing over 70% of the abuse in one recent, large study of recent victimization experiences (Gewirtz-Meydan & Finkelhor 2020). Colorado Revised Statutes §19-3-304 governs mandatory reporting in Colorado. All public and private school officials and employees may be among those required by law to report suspicions of abuse.

There are a multitude of free, governmental and nonprofit partners who offer free resources and training to assist schools in identifying and addressing sexual behavior in children. Refer to page 33 for the Resources section.

Other state departments have provided additional resources to assist schools in working with youth who display sexual behavior problems. The Attorney Generals' Office in the Department of Law has created a legal manual to prevent school violence. Colorado School Violence Prevention: A Legal Manual, is available for free download.

In addition to Colorado resources, the U.S. Department of Education (USDE) houses the Office for Civil Rights, which is charged to ensure equal access to education and to promote educational excellence through vigorous enforcement of civil rights in our nation's schools. They maintain a robust database containing reports and resources supporting students and schools.

The Colorado Department of Education has embellished USDE's resources with a comprehensive website to support Colorado schools. CDE maintains a listserv of school

personnel interested in Title IX for regular updates on training events and changes in the law. https://www.cde.state.co.us/cde_english/titleix

The USDE contracted for and funds the National Center on Safe Supportive Learning Environments (NCSSLE) within the Office of Safe and Supportive Schools. NCSSLE is dedicated to improving school climate and conditions for learning. The Center offers information and technical assistance to states, districts, schools, and institutions of higher learning to accomplish its mission.

One NCSSLE resource available to schools to aid in compliance with Title IX is the Safe Place to Learn toolkit. The toolkit contains materials to support school efforts to prevent and eliminate peer-to-peer sexual harassment and sexual violence.

Training

In order for school communities to identify and address sexual behavior in children, training is essential. As best practice, staff should be trained in childhood sexual development, identifiers of trauma and abuse, mandated reporting, and awareness of predatory behaviors and boundary violations.

Research has demonstrated that comprehensive human sexuality education prevents child sexual abuse. It educates children on anatomical and reproductive functions; but also issues of consent, bodily autonomy and boundaries, which provide a model for healthy relationships. Children must understand which behaviors are sexual before they can appreciate that unwelcome sexual behaviors can be problematic, or even criminal. The Colorado Department of Public Health and Environment offers grant funding for schools/districts interested in implementing Comprehensive Human Sexuality Programming.

Summary

The socio-ecological model reminds us that training school staff is just a start. Extending programming to the entire school community promotes consistent messaging and allows families to instill cultural, religious, and personal values as they deem appropriate. Engagement with caregivers promotes trust, extends learning opportunities, and provides added layers of protection for the entire community.

Literature and research on children with sexual behavior problems

Incidence and prevalence of sexual behavior problems among children under age 12

It is widely recognized that childhood is a stage of development signified by vast gains in knowledge, adaptation, and growth. Children display a natural and typical curiosity in most aspects of their body, family, environment, culture, and society. Sexuality is no different. Each child may express this curiosity in unique and individual ways, depending upon their age, exposure, and experiences. Most often this is relatively harmless and represents typical (healthy) sexual exploration. However, as defined below, there are sexual behaviors committed by children that do pose a significant harm and non-negligible risk for recidivism.

> *"Sexual assaults against children are often committed by other youth. Crime statistics have shown that approximately 15-20% of all sexual offenses and up to 50% of all child molestations may be committed by youth under 18 years of age (Zolondek, Abel, Northey, & Jordan, 2002). In a recent telephone survey of a nationally representative sample of over 2000 youth, 72% of all sexual assaults against children were found to involve offenders who were under 18 years of age (Finkelhor, Ormrdo, Turner, & Hamby, 2005). Early adolescence appears to be the peak or modal age for committing sexual offenses against children (see Caldwell, 2002 for an analysis of NIBRS reports). However, sexually aggressive behaviors have also been reported among school age children as well as children as young as 3 years (Bonner, Walker, & Berliner, 1999; Friedrich & Luecke, 1988; Johnson, 1988; Pithers, Gray, Busconi, & Houchens, 1998; Silovsky & Niec, 2022)."* [10 Year Follow-up Supports Cognitive-Behavioral Treatment for Children with Sexual Behavior Problems: Implications for Services, Treatment Implementation, and Future Directions. Carpentier, M., Oklahoma State University, Silovsky, J. & Chaffin, M.]

Not much is currently known of the prevalence and incidence of children with sexual behavior problems (PSB); however, available statistics indicate the reporting of these types of PSB among children (and early adolescents) has been increasing significantly over the last decade or more.

> *"No population-based figures are available on the incidence or prevalence of sexual behavior problems in children. Rates of sexual behavior problems among groups of traumatized youth are higher than the general population (Friedrich, 1998; Kendall-Tacket, Williams, & Finkelhor, 1993). Although not limited to sexually abused children, child sexual behavior problems occur among as many as 1/3 of sexually abused children. Prevalence rates among children with other or multiple sources of trauma remains unclear. Recent years have seen an increase in the number of children with PSB who have been referred to child protective services, juvenile services, and treatment in both outpatient and inpatient settings (Burton, Butts, & Snyder, 1997; Vermont Social and Rehabilitative Services, 1996 – cited in Gray et al., 1999). It is not known whether this represents a true increase in the incidence of such behaviors, changing definitions of problematic sexual behavior, increased awareness, and reporting of what has already*

existed, or some combination of these factors." [10 Year Follow-up Supports Cognitive-Behavioral Treatment for Children with Sexual Behavior Problems: Implications for Services, Treatment Implementation, and Future Directions. Carpentier, M., Oklahoma State University, Silovsky, J. & Chaffin, M.]

This subset of higher risk children is small in comparison to the majority, as most children with PSB respond well to lesser intensity treatment interventions. Most children with PSB present a low risk to recidivate and can be redirected effectively and constructively by parents, teachers, and specially trained therapists to modify and correct their problematic sexual behaviors with developmentally appropriate, culturally sensitive, individualized treatment plans. However, by comparison, there does exist a small subset of children who exhibit more severe (atypical) problematic sexual behaviors (likely involving coercion, force, and/or penetration) who do not respond as well to lesser intensity treatment interventions and are of notable concern for on-going problematic sexual behaviors.

In 2018, The Journal of Child Sexual Abuse published an article, Scientific Evolution of Clinical and Risk Assessment of Sexually Abusive Youth: A Comprehensive Review of Empirical Tools, authored by L.C. Miccio-Fonseca and L. Rasmussen, which reported the following:

> *"Although rarely reported to police, many children ages 4-12 years participate in serious sexually abusive behaviors (Miccio-Fonseca & Rasmussen, 2014). The U.S. FBI National Incident-based Reporting System (NIBRS) reported 13,471 juveniles (93% males) committed sex crimes against minors in 2004 (Finkelhor, Ormrod, & Chaffin, 2009). Sixteen percent were youth ages 6-12, more females in this age group than the rest of the sample (i.e., 14.6% vs. 5.9%). They committed less rape than adolescents (11.0% vs. 26.4%), however, more sodomy (15.4% vs. 11.9%) and more sexual assault with objects (7.2% vs. 4.2%). Notably, sex offenses committed by preadolescents ages 10-12 increased from 1980 to 2010 by 67% (Sickmund & Puzzanchera, 2014)."*

Even though research on children with PSB is limited at this time, due to many complicating factors in obtaining accurate data (i.e., issues with reporting, absence of standardization of treatment interventions, inconsistent follow-up and tracking of long-term outcomes, etc.), three important studies have begun to elucidate some potential directions for future research into this subpopulation of children. These studies are (1) Carpentier, Silovsky, and Chaffin's (2006) 10-year prospective longitudinal study of 135 children, ages 5-12, identified as having "sexual behavior problems," which found less than 10% of the sample had sex offense arrests or child perpetration reports; (2) Grossi, Brereton, Lee, Schuler, and Pretky's (2017) prospective study of archival data of a child welfare sample (N = 638 youth, ages 2-17, mean follow-up 36.7 months) found the highest rate of new hands-on problematic sexual behaviors in youth initially exhibiting problematic sexual behaviors at ages 2-7 years; and (3) Lussier, McCuish, Mathesius, Corrado,

and Nadeau (2018) utilized a revised version of the Child Sexual Behavior Inventory (Friedrich et al. 2001, as cited in Lussier et al.) with a normative sample of 374 preschoolers from 3 to 8. They identified "four distinct sexual development trajectories" (p. 622). Those children were characterized by "a high rate increasing trajectory" (p. 651) of sexually intrusive behaviors (SIB) (boys, 13% of sample) showed "evidence of SIB after school entry" (pp. 651-652). The study did not find that a particular group of children were more at risk for sexually abusive behavior in adolescence. [L.C. Miccio-Fonseca & Lucinda A. Lee Rasmussen (2018) Scientific Evolution of Clinical and Risk Assessment of Sexually Abusive Youth: A Comprehensive Review of Empirical Tools, Journal of Child Sexual Abuse, 27:8, 871-900, DOI: 10.1080/10538712.2018.1537337]

It is important to emphasize that most children with PSB respond well to treatment interventions and do not continue to exhibit these behaviors into adolescence and/or adulthood. For many of these children and their families, there is significant hope and promise that with the appropriate treatment intervention, these children will continue along a healthy developmental trajectory, free from sexual concerns or issues.

Defining atypical sexual behaviors among children

It is of paramount importance then, that as a field of study, there exists a clear and applicable definition of what constitutes an atypical problematic sexual behavior for a child and how to distinguish levels of risk among children. In 2006, The Association for the Treatment of Sexual Abusers (ATSA) published their report of the Task Force on Children with Sexual Behavior Problems and outlined these guidelines for determining if a child's sexual behavior is of concern:

> *"Children (ages 12 and younger) who initiate behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others. Although the term sexual is used, the intentions and motivations for these behaviors may or may not be related to sexual gratification or sexual stimulation.*
>
> *In determining whether sexual behavior is **inappropriate**, it is important to consider whether the behavior is common or rare for the child's developmental stage and culture; the frequency of the behaviors; the extent to which sex and sexual behavior have become a preoccupation for the child; and whether the child responds to normal correction from adults or continues to occur unabated after normal corrective efforts.*
>
> *In determining whether the behavior involves the **potential for harm**, it is important to 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; if the behavior appears to be interfering with the child(ren)'s social development; and if the behavior causes physical injury."

Etiology of PSB among children

Current research into the development and etiology of PSB among children is emerging but still in its infancy of study. One recent study performed logistic regression models as a method of identifying developmental covariates of childhood-onset PSB and its persistence into adolescence. The early findings of this study suggest that children with childhood-onset PSB that persisted into adolescence had experienced various life adversities. Despite commonly held beliefs among the public that early childhood sexual victimization is somehow a prerequisite for later childhood and adolescent sexual offending, the aforementioned study found that although sexual victimization can be a component of the developmental antecedents for some youth with PSB, most youth with PSB represent a developmental history which is far more complex and extremely heterogeneous (e.g., Lussier et al., 2019; Wanklyn et al., 2012).

> *"For example, a study conducted by Vizard, Hickey, French, & McCrory, (2007) showed that various factors related to family environment--exposure to intimate partner violence, inconsistent parenting, lack of parental supervision, lax sexual boundaries, and physical neglect—were commonly observed among youth with PSB and most were correlated with PSB that developed early in childhood (i.e., before 10 years of age) and continued into adolescence."* [Chouinard-Thivierge, S., Lussier, P., Daignault, I. A Longitudinal Examination of Developmental Covariates of Sexual Behavior Problems among Youth Referred to Child Protective Services. Sexual Abuse 2022, Vol. 34(5) 537-567.]

Increasingly evident is the importance of early attachment bonds with parents/caregivers and the socio-ecological context in which the child is being raised.

> *"Attachment theories related to sexual offending in adolescence have stressed the role and importance of Adverse Childhood Experiences (ACEs)other than sexual abuse. Attachment bonds between parents and children are understood to be pivotal because they provide the foundation for the child's internal representations of self and others, as well as the basis for future social interactions (e.g., Marshall, 1989; Marshall et al., 1993). Poor parenting (e.g., neglect, abuse, and violence) and disruptions in parenting early in a child's development can result in insecure attachment bonds (e.g., Grady et al., 2017; Smallbone, 2006; Smallbone & Dadds, 2000) that can negatively influence children's social interactions, leading to difficulties that may affect their sociosexual development after puberty (e.g., Marshall & Barbaree, 1990)."* [Chouinard-Thivierge, S., Lussier, P., Daignault, I. A Longitudinal Examination of Developmental Covariates of

Sexual Behavior Problems among Youth Referred to Child Protective Services. Sexual Abuse 2022, Vol. 34(5) 537-567.]

The importance of a comprehensive evaluation with specific recommendations for treatment implementation

Recidivism studies of sexually abusive youth have historically been primarily comprised of male adolescents. Actual sexual recidivism rates remain unknown for such populations as non-adjudicated youth, children under 12, females, transgender youth, and youth with low intellectual functioning. Recidivism studies are challenging to conduct, as sexual abuse is often not reported and not all sexually abusive youth are reported, investigated, or sanctioned.

Essential to the prevention and treatment of any PSB is the ability to identify risk factors related to the initiation and continuation of the PSB within a real-world context. Traditionally, well-intended (albeit misguided) behavioral research has relied on formerly identified patterns of risk-related behavior among adult (male) offenders and then attempted to transpose some version of these adult-based templates onto the assessment of risk for recidivism among younger juvenile populations. As is now well-established, this is not an appropriate method of determining risk level and formulating treatment plans for juveniles with sexually abusive behaviors, as the neuroscience of the developing adolescent brain is markedly different from the adult brain, among many other gender-informed and developmental differences.

> *"Sexually abusive youth vary in risk and protective factors (dynamic and static). There is very limited research for different age groups and gender. "One size does not fit all" in risk assessment; tools need to be sensitive to within-group differences of age, gender, and intellectual functioning. Most risk assessment tools were created for assessing adjudicated male adolescents. They are inadequate for assessing females, transgender youth, children under 12, and/or youth with low intellectual functioning."* [L.C. Miccio-Fonseca & Lucinda A. Lee Rasmussen (2018) Scientific Evolution of Clinical and Risk Assessment of Sexually Abusive Youth: A Comprehensive Review of Empirical Tools, Journal of Child Sexual Abuse, 27:8, 871-900, DOI: 10.1080/10538712.2018.1537337]

In fact, many widely accepted risk factors among juveniles (13-18 years old) are currently under reconsideration for validity among prominent researchers in the field due to a lack of supporting empirical evidence.

> *"Worling and Langstrom (2003, 2006) contend that most risk factors commonly associated with juvenile sexual offending lack empirical validation. Describing 21 commonly cited risk factors, Worling and Langstrom (2006) argue that only five—deviant sexual arousal, prior convicted sexual offenses, multiple victims, social isolation, and*

> *incomplete sexual offender treatment—are empirically supported through at least two published independent research studies, and that only two other factors—problematic parent-child relationships and attitudes supportive of sexually abusive behavior—have empirical support in at least one study and thus can be considered "promising" risk factors."* [SOMAPI Research Brief: Sex Offender Management Assessment and Planning Initiative, July 2015. The Assessment of Risk for Sexual Re-offense in Juveniles Who Commit Sexual Offenses, Phil Rich, Ph.D., 2015.]

Likewise, it is not advisable to apply current juvenile models of risk assessment and treatment modalities to children (under 12 years of age) that are based on research conducted on juveniles (ages 13-18). Like most life stages, childhood development represents a diverse and complex period of the life span. Special considerations should be given to the dynamic and evolving nature of a child's unique identity and development.

Risk assessment tools for use with children (and early adolescents) exhibiting PSB

A small number of risk assessment tools have been developed in recent years and are worth noting because of their assimilation of protective factors. "Farrington and Ttofi (2011) asserted that a protective variable interacts with a risk factor to nullify its effect. Notably, there are relatively few articles on the impact of protective factors on recidivism (van der Put & Assher, 2015, p.111)." [SOMAPI Research Brief: Sex Offender Management Assessment and Planning Initiative, July 2015. The Assessment of Risk for Sexual Re-offense in Juveniles Who Commit Sexual Offenses, Phil Rich, Ph.D., 2015.]

Some available tools for children with problematic sexual behaviors, which include protective factors in their risk assessment instruments, are as follows: (1) Assessment, Intervention, and Moving On Project 2 (AIM2) for children under twelve years of age (Print et al., 2007), (2) the Latency Age-Sexual Adjustment and Assessment Tool (LA-SAAT) (Rich, 2011), and (3) the Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually Abusive Adolescents and Children (MEGA) for ages 4-19 (Miccio-Fonseca, 2010). More information on these individual tools is given below.

> Assessment, Intervention, and Moving On Project 2 (AIM2)
>
> *"The AIM Project offers two models for children under 12 years old: one for children under 7 years (which involves Pattern Mapping; pattern mapping is a visual framework capturing key life events and sexual behaviors), the other for older children aged 8-12 years old, which is a dynamic risk assessment model framework not an actuarial risk assessment tool. Both models are designed to be visual and easily updated at review*

points to highlight progress being made to facilitate communication with parents, children, and professionals. (Carson, 2019)

The AIM Under 12s model for children aged 8–12 years old, is a framework for professional analysis and decision making. There are five domains, with five factors within each domain looking at different aspects which need to be considered to give an overall outcome for that domain. In addition, each factor has several items provided to support the professional analysis, and these can be added to by information which is unique to a particular child or their family. Within each domain professionals are asked to consider both strengths and concerns. (Carson, 2019)

The factors are scored as follows: zero, no general concern or it is an area of strength; two, for some concern; four, where there is significant concern. The scores for all 5 factors within each domain are then collated to give an outcome for the domain. Once all 5 domains are scored, this provides a visual profile graph of the child in their context indicating areas of significant concern which would be red (scores of 14-20); areas which indicate work is required which would be amber (scores of 6-12) and areas which are not a concern or are potentially strengths which would be green (scores of 0-4) (Carson, 2019)."

[Helen Louise Griffin, Anthony Beech, Bobbie Print, Helen Bradshaw & Jeremy Quayle (2008) The development and initial testing of the AIM2 framework to assess risk and strengths in young people who sexually offend, Journal of Sexual Aggression, 14:3, 211-225, DOI: 10.1080/13552600802366593 To link to this article: https://doi.org/10.1080/13552600802366593]

The Latency Age-Sexual Adjustment and Assessment Tool (LA-SAAT)

"The LA-SAAT is an instrument designed to shape structured professional judgment (SPJ) in assessing the risk for continued sexually troubled behavior in pre-adolescent males, aged 8-13 (14th birthday), who have engaged in sexual behavior that appears inappropriate due to age or the nature and/or extent of the sexual behavior. In children who have behaved in sexually problematic or sexually abusive behavior, the LA-SAAT will help evaluators assess the risk for future problematic sexual or sexually abusive behavior (sexual re-offending). It is not designed to be used to evaluate younger children, adolescents, adults, or females.

It is not possible to assess risk for continued sexually abusive behavior in absence of previously sexually abusive behavior. Under these circumstances, it is not possible to assess risk for a re-offense, although the LA-SAAT is designed to assess risk for

continued sexually abusive or troubled sexual behavior, even if not sexually abusive in nature.

Predictions about future behavior in children and adolescents are fluid and likely to change over time due to the physical, emotional, and cognitive development of the juvenile, as well as the impact and effect of the social environment and/or treatment. Accordingly, risk for future behaviors in juveniles, including risk for continued sexually troubled behavior, should be periodically re-assessed, and any risk assessment should be considered valid only for a period of approximately one year or less.

The LA-SAAT may be used to re-evaluate risk over time. However, the LA-SAAT Interim Re-Assessment (LA-SAAT/IR), a companion instrument to the LA-SAAT, is designed for the purposes of re-assessment for juveniles previously assessed with the LA-SAAT."

Link: http://www.philrich.net/risk-assessment-instruments.html

Multiplex Empirically Guided Inventory of Ecological Aggregates for Assessing Sexually Abusive Adolescents and Children (MEGA)

"MEGA is an empirical actuarial risk assessment tool, with calibrated risk categories grounded on given algorithms (i.e., statistically weighted risk and/or protective factors according to age and gender). MEGA has been validated multiple times on large representative samples of males and females, ages 4 to 19 (adjudicated and non-adjudicated), including youth with low intellectual functioning (Miccio-Fonseca 2009, 2010, 2013a, 2016a, b, 2018a, b). Validation study on 1184 male and female youth, ages 4-19, including youth with low intellectual functioning of borderline or below average range, established the four scales: Risk Scale (with four distinct risk levels, Low Moderate, High, and Very High), a Protective Scale, and two clinical scales: Estrangement, and Historic Correlative. Risk Scale provides the overall risk of the youth, based on static and dynamic factors. Protective Scale identifies salient variables that may mitigate risk. Two clinical scales provide instructive information for supervision, treatment, case management, and monitoring, given current data regarding the youth's day-to-day functioning. Estrangement Scale relates to relationships the youth has and the manner and/or behaviors in those relationships. Historic Correlative Scale alerts one to sexual concerns of a historical nature (e.g., youth in the past has sexually abused multiple victims).

Findings of the MEGA Combined Samples Studies on a large diverse sample of close to 4000 youth, ages 4-19 years, provides evidence that most sexually abusive youth (about 60%) are in the Low and/or Moderate range of risk level. The percentage of Low to Moderate 4–12-year-old youth in the MEGA Combined Samples Studies was even higher

(77.3%), affirming the need for accurate risk assessment to identify those few children and preadolescents that are high risk, as well as preventative services to decrease coarse sexual improprieties, deter any future sexually abusive behavior, and ensure that the risk level of those assessed at Low to Moderate does not increase over time."

Link: https://www.mega-miccio-fonseca.com/

Trauma and trauma-related symptoms in children with PSB

As referenced earlier in the etiology of PSB among children section, a child's experience of trauma or exposure to traumatic events in their environment serves as a critical component to assessing the child's overall psychological development and physical health. Any evaluation conducted on a child with problematic sexual behaviors should involve some type of exploration into the child and family's history of trauma and trauma-related events. Care and caution should be used to avoid re-traumatization of the child and family members in clinical interviewing. The questionnaires and surveys below can assist in obtaining the relevant information about trauma history without as great a risk of re-traumatization. The interview atmosphere should be supportive and any pressure to reveal information *should not be applied*. Clinical interviewers should expect children to be reluctant to reveal the truth and details about events that may be upsetting to the child.

Adverse Childhood Experiences (ACEs) Study and Questionnaire

"The Adverse Childhood Experiences (ACE) Study, a collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego, is one of the largest research endeavors ever conducted to examine associations between childhood adversity and adult health (Centers for Disease Control and Prevention, 2013). The original ACE questionnaire assessed 7 categories of ACEs: 3 categories of child maltreatment (psychological abuse, physical abuse, and sexual abuse) and 4 categories of household dysfunction (mother treated violently, living with a household member who was a substance abuser, mentally ill or suicidal, or was ever imprisoned). Subsequent ACE studies incorporated neglect and parental divorce or separation into the ACE index. The CDC-Kaiser ACE studies reported a strong, graded relationship between the number of ACEs a person was exposed to and the risk for cancer, ischemic heart disease, liver disease, substance abuse, depression, and chronic obstructive pulmonary disease, among other health problems (Felitti et al., 1998). Since then, numerous investigators have reported the link between ACE exposure and social and health problems, including teen pregnancy (Hillis et al., 2004); autoimmune disease (Dube et al., 2009); and use of psychotropic medications (Anda et al., 2007).

Internalizing (e.g., anxiety, depression) and externalizing (e.g., aggression) problem behaviors, have been observed to have a higher likelihood of emerging after exposure to childhood adversity. In a study examining ACEs among a pediatric sample, exposure to 4 or more ACEs was associated with 33 times the odds of reporting a learning or behavioral problem as compared to children without ACE exposure (Burke, Hellman, Scott, Weems, & Carrion, 2011). Other studies have found substantial increases in attention and behavioral problems among children as young as 5 after cumulative ACE exposure (Jimenez, Wade, Lin, Morrow, & Reichman, 2016; McKelvey, Whiteside-Mansell, Conners-Burrow, Swindle, & Fitzgerald, 2016). These studies advance the ACE literature by indicating that cumulative adversity is not only associated with strong effects on adulthood health outcomes but also childhood behavioral problems."

Tenah K.A. Hunt, Kristen S. Slack, Lawrence M. Berger, Adverse childhood experiences and behavioral problems in middle childhood, Child Abuse & Neglect, Volume 67, 2017, Pages 391-402, ISSN 0145-2134, https://doi.org/10.1016/j.chiabu.2016.11.005.

Link for ACE Administration and Questionnaire: https://www.chcs.org/media/TA-Tool-Screening-for-ACEs-and-Trauma_020619.pdf

The Trauma Symptom Checklist for Young Children

"The Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005) is a well-validated caregiver report measure for young children ages 3 to 12 that provides a broadband assessment of various trauma-related symptoms, including posttraumatic stress, dissociation, and depression. Notably, the TSCYC includes a scale directly assessing sexual concerns. The companion child-report measure, the Trauma Symptom Checklist for Children (TSCC; Briere, 1996), is appropriate for children ages 8 to 16 and assesses symptom categories similar to the TSCYC."

Link: https://www.parinc.com/products/pkey/463

Child Sexual Behavior Inventory

"Child Sexual Behavior Inventory (CSBI; Friedrich, 1997) is a caregiver report questionnaire for children between the ages of 2 and 12 years. It asks caregivers to identify the frequency of 38 different sexual behaviors, including interpersonal, self-stimulating, and exhibitionistic behaviors, among others."

Link: https://www.nctsn.org/measures/child-sexual-behavior-inventory

Please see Appendix A for more information.

Evidence-informed treatment interventions based on risk and needs

Multiple studies have emerged regarding treatment interventions for children with PSB. These studies have examined a variety of interventions and modalities, including individual, group, family, and play therapies, some of which target the problematic sexual behaviors directly and others indirectly. Evidence-based treatments designed to primarily target PSB in children are largely group interventions that use cognitive behavioral therapy (CBT) and are time-limited (Chaffin et al., 2006). Below is a summary of significant findings related to treatment the treatment of children with PSB:

> *"More structured programs demonstrate greater improvement in problematic sexual behaviors in comparison to less structured interventions. For example, compared to a play therapy group (Bonner, Walker, & Berliner, 1999), children randomly assigned to a CBT group demonstrated fewer sex offense arrests at 10-year follow-up (Carpentier, Silovsky, & Chaffin, 2006). Additional studies looking at CBT format interventions found improvements with this population. (Pithers, Gray, Busconi, & Houchens, 1998).*
>
> *Interventions with preschool children are especially effective, as demonstrated by Silovsky and colleagues (2007) who successfully treated children ages 3-7 and their caregivers in a group program. Interventions targeted at preschool-age children resulted in the greatest improvement, perhaps because parent practice elements like behavior management are better implemented at that age.*
>
> *Interventions that target traumatic stress with PSB as a secondary symptom have also demonstrated improvements in children with PSB. Comparisons of Sexual Abuse Specific (SAS) Cognitive Behavior Therapy (CBT) with Nondirective Supportive Therapy (Cohen & Mannarino 1998, 1996) have consistently demonstrated more improvements of PSB's in the SAS CBT groups. Trauma-Focused CBT has also improved PSB relative to supportive therapy (Deblinger, Stauffer, & Steer, 2001).*
>
> *St. Amand and colleagues (2008) conducted a meta-analysis of 11 treatment outcome studies evaluating 18 specific interventions for PSB in young children. They limited their review to studies of children between ages 3 and 12 and to short-term outcomes, given the dearth of long-term outcome studies. Several characteristics of treatment were examined, including specific practice elements rather than whole treatment models (e.g., cognitive coping vs. TF- CBT); treatment type (CBT, play therapy); treatment modality (individual, group,*

> *family); and therapist approach (directiveness, limit setting, and use of modeling/practice). The analysis indicated that overall, the degree of change in PSBs following treatment is .46, a medium effect size statistically but a substantial amount clinically, indicating that treatment does work with a heterogeneous group of children (St. Amand et. al, 2008).*
>
> *Treatment modality (individual vs. group) is less important than specific practice elements (St. Amand et al., 2008)."*
>
> [TDMHSAS BEST PRACTICE GUIDELINES, *Children with Sexual Behavior Problems*, Workgroup Members: Melissa L. Hoffman, PhD, University of Tennessee Center of Excellence for Children in State Custody – Chairperson; Bonnie Beneke, LSCW, Tennessee Chapter of Children's Advocacy Centers; Tarah M. Kuhn, PhD, Vanderbilt University; and Melissa James, LCSW, University of Tennessee Health Science Center, 2013.]

One uniformity across all effective interventions for reducing PSB among children has been the direct involvement of the caregivers in the treatment, particularly teaching caregivers how to use behavior management approaches. Support for the involvement of parents in the treatment of PSB is also found in the related literature on disruptive behavior disorders. Most childhood PSB are like other behavior problems in a variety of ways: "the behaviors involve behavioral disinhibition, problems with impulse or emotion regulation, social rule-breaking, and may include aggressive acts toward self or others (Silovsky, Niec, et al., 2006). Further overlap is found in the factors that contribute to the development and maintenance of both non-sexual disruptive behavior problems and sexual behavior problems (e.g., history of violence exposure, poor supervision, parent-child relationship)." [10 Year Follow-up Supports Cognitive-Behavioral Treatment for Children with Sexual Behavior Problems: Implications for Services, Treatment Implementation, and Future Directions. Carpentier, M., Oklahoma State University, Silovsky, J. & Chaffin, M, 2006]

> *"Family involvement in treatment has been considered critical to the success of services for children with problematic sexual behaviors (Bonner et al., 1999a; Friedrich, in press; Silovsky et al., 2006). The importance of working on the quality of the parent (caregiver) – child relationship is particularly emphasized in Friedrich's Attachment-Based Family Therapy model (Friedrich, in press)."* [10 Year Follow-up Supports Cognitive-Behavioral Treatment for Children with Sexual Behavior Problems: Implications for Services, Treatment Implementation, and Future Directions. Carpentier, M., Oklahoma State University, Silovsky, J. & Chaffin, M, 2006]

It cannot be emphasized enough how caregivers often benefit from information about sexual development, guidelines of how to differentiate typical sex play from PSB, and ways to teach and enforce rules about sexual behavior and physical boundaries. In addition, caregivers often need clear instruction on recommendations for supervising and monitoring the child with PSB across different scenarios.

In summary, of greatest importance in treating children with PSB is the individualization and differentiation of treatment based upon the child's clinical presentation and potential risk for continued problematic behaviors. Current literature reviews indicate treatment and supervision have been shown to be very successful with high-risk youth in deterring further sexually abusive behavior when evidence-informed interventions are conducted with individualized treatment planning, and when the youth and family are engaged in the process. The active participation of the parents (caregivers) in treatment is crucial. If left untreated, the risk posed by untreated children with PSB is unknown but may not be insignificant given that 10% of children receiving less effective treatment had future sex offense arrests or reports.

For more information, see Appendices B and C.

Public policy implications for children with PSB

Public policy should promote and make accessible appropriate treatment for children with PSB where clinical assessment suggests it is needed. A child's assessment would be best conducted by an experienced, licensed clinician with specialized training in children's PSB in order to ethically perform such an evaluation. In terms of prioritizing community safety and reducing further potential for victimization, policymakers should be most appropriately concerned with the subset of children who engage in the most serious and victimizing behaviors. Formal multi-systemic involvement may be necessary in securing needed services, protecting communities, or as an appropriate response to particularly egregious behavior. Within this smaller subset of children, legal proceedings may be undertaken in certain high-risk cases, if necessary to ensure receipt of needed services.

Of relevance to professionals involved in these cases, there may be situations in which the parents or caregivers were informed of ongoing abusive sexual behaviors and failed to intervene or protect other children. In this circumstance, a report to authorities may be warranted. As a guide, mandatory reporting may be most appropriate when both of the following conditions are true: (1) the behavior has involved significant harm or exploitation (i.e., where a child has used physical and/or emotional coercion, bribes or threats, to gain compliance or reduce the resistance of another child; or where the age or developmental difference between the children indicated substantial inequality) AND (2) the behavior is serious or persistent (i.e., oral-genital contact or penetration, penile-anal contact or penetration, penile-vaginal contact or penetration, digital

contact or penetration of rectum or vagina; or other sexual behaviors of a less advanced nature that persist despite efforts to correct them or admonitions to stop).

The consequential decision of whether to place a child with PSB in out-of-home placement requires careful thought and consideration of all affected. Out-of-home placement is not automatic, even in cases where a child has sexually victimized another child in the same home. Rather, a thorough case-by-case assessment by clinical professionals trained in evaluating children with PSB and their families would best inform a multi-disciplinary team of the appropriate level of placement for the child. Retaining all children in their homes, families, and communities is understandably preferred, if appropriate and safe. However, out-of-home placement should be considered for those cases where retaining the children in the home is not viable either because it would cause harm or significant distress to the other child(ren), because of the acute needs for treatment or protection or because caregivers are not providing an adequately safe environment. If an alternative placement is required, priority should be given to the least restrictive, closest-to-home placement, where family involvement in treatment can be accommodated. Often with the help of the family, an alternative temporary living arrangement can be identified for the child with PSB involving close, trusted extended family or friends, who do not have younger children in their home.

Summary

It is important to emphasize that this sub-population of higher risk children with more harmful problematic sexual behaviors is rare, but it is critical to community safety to be able to detect and treat these children and their families effectively. Given the indications of the current research and the developing data on assessment and treatment interventions, families and communities should have a sense of optimism about the likely potential of successful outcomes for any child and corresponding family, coping with problematic sexual behaviors. The prognosis is good if these behaviors are recognized early, accurately and responsibly handled, and the involved systems respond with evidence-based and scientifically guided evaluation and treatment.

It is necessary for all involved systems to collaborate openly and coordinate their responses for the child and family. Lastly, it is paramount that the involved professionals consider that these are merely children, whose behaviors serve as a barometer for the environment in which they are developing. A compassionate approach to these children and their families can lay the groundwork for positive outcomes.

> *"The fact remains that a significant amount of child sexual abuse and related behaviors is committed by children and teenagers. The fact remains that some currently unknown, but probably not insignificant, proportion of youthful abusers continue abusive behavior into adulthood and that adult abusers who have adolescent onsets may be responsible for*

a higher-than-usual number of events. To the extent that we can identify those truly at risk and work productively with them, our communities will be safer. But in the process, we should not forget that these are our children. And as professionals committed to children's rights and welfare, we should think carefully about their rights and welfare before responding to their behavior." [Don't Shoot, We're Your Children": Have We Gone Too Far in Our Response to Adolescent Sexual Abusers and Children with Sexual Behavior Problems? Mark Chaffin and Barbara Bonner, Child Maltreat 1998 3:314.]

Treatment for problematic sexual behavior

The SOMB has purview over youth ages 10 and over who have been adjudicated for a sexual crime, but not those who are identified through non-court based mechanisms. The SOMB Standards and Guidelines may be used as best practice with youth over age 10 who are not under the statutory purview of the SOMB but it is highly recommended children with problematic sexual behavior be evaluated by and referred to treatment with mental health professionals who are licensed, registered, or certified pursuant to the articles contained in C.R.S § 12-43-303, 1243-403, 12-43-503, 12-43-601.5 and 12-43-803. These define the practice of psychiatry, psychology, social work, marriage and family therapy, licensed professional counseling, and addiction counseling, respectively. Mental health professionals are registered, licensed, or certified through the Colorado Department of Regulatory Agencies.

Providing treatment to children with problematic sexual behavior requires advanced expertise not offered in traditional graduate course work. It is important for professionals to understand and respect the limitations of their practice and the advanced expertise required to properly serve youth and not practice outside of or beyond his or her area of training, experience, or competence.

Individuals working with children with sexual behavior problems may seek additional resources with The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect, and the Tennyson Center for Children. Additional resources are listed at the end of this document.

Recommendations for professionals working with children with problematic sexual behavior – Sex Offender Management Board Best Practices Committee/Children with Problematic Sexual Behavior Sub-Committee

The SOMB Best Practices Committee/Children with Problematic Sexual Behavior Sub-Committee offers the following recommendations regarding children with PSB:

1) When a child with PSB is identified by a child-serving systems agency as in need of services, it is essential that the system immediately intervene, refer to the appropriate treatment services, and ensure compliance with all treatment requirements. In this context, a systems agency may include the juvenile justice system and related agencies, child welfare agencies, schools, and other child serving organizations. Actors should be mindful of and attempt to mitigate the potential for their intervention to traumatize or retraumatize impacted families.

2) A multidisciplinary approach is important to provide the best outcomes for children with PSB. These children with PSB and their families may be involved with multiple different government and private agencies, and it is essential that there be cross-collaboration among professionals working with the child. In particular, it is also essential that all agencies, particularly those that require and fund services, stay engaged with the child and the child's family until treatment is completed.

3) A range of treatment services should be available for children with PSB from less intensive psychoeducation based interventions to more intensive treatment for children with PSB. Practitioners working with this population should have proper training and experience, and although not required for non-adjudicated children, an SOMB-approved juvenile treatment provider may be a suitable resource for such intervention.

4) Treatment services for children with PSB can be expensive and unaffordable for a family. Support and financial assistance from agencies involved with the child and family may be helpful to ensure the child and other family members are able to complete treatment when it is warranted.

5) Treatment for children with PSB should be assessment-driven, and should be individualized for each child. Not all children have the same treatment needs. A good assessment can determine what level of risk the child poses for future PSB and the level and intensity of the recommended intervention. All treatment interventions provided to children with PSB should be based on treatment needs, and treatment approaches should follow research-informed best practices.

6) School personnel are often the first point of contact for a child with PSB. The SOMB School Resource Guide provides helpful information for school personnel dealing with this population. School personnel may also be included in the multidisciplinary approach for working with children with PSB.

7) Parental and/or guardian involvement is critical in working with children with PSB. Agencies who are overseeing these cases should identify mechanisms to ensure supervisory adult participation where possible.

8) Given the potential negative outcomes associated with labeling children with PSB as "sex offenders" and "perpetrators," care should be utilized by agencies and systems to avoid administrative and legal actions that may label these children. One way to accomplish this may be to look at alternatives to adjudication for children ages 10-12 with PSB such as diversion and informal adjustment. Adjudication may be suitable for a small subset of children with PSB who exhibit the most severe behaviors and pose the highest risk to the community for future PSB, but care should be exercised in decisions to prosecute such cases.

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Appendix A: Outline for risk assessment of children with PSB

"1. Individualized risk assessment, treatment planning, and decision making on a case-by-case basis

2. Thorough assessment of the child's context, social ecology, and family environment

3. Understanding and accounting for the changes in environment necessary for sustained changes in the child's behavior

- *Quality of the caregiver-child relationship, including the level of positive adult caregiver engagement with the child*
- *Adult caregiver capacity to monitor and supervise behavior*
- *Caregiver warmth and support shown toward the child*
- *Presence of positive or negative role models and peers in the child's social environment*
- *Types of discipline, limits, structure, or consequences applied, the level of disciplinary consistency and the child's response*
- *Emotional, physical, and sexual boundary violations in the home*
- *Availability of opportunities for inappropriate behavior*
- *Extent and degree of sexual and/or violent stimulation in the child's past and current environment*
- *Exposure to and protection from potentially traumatic situations*
- *Cultural factors of the home and community (including racial, ethnic, religious, socioeconomic, etc.)*
- *Factors related to resilience, or strengths and resources that can be developed*
- *Ecologically focused assessment is critical*
- *Ecologically focused assessment also integrates information about permanency planning for children in the State's custody*

4. Include broad psychological and behavioral status

- *A number of non-sexual problems have been described among children with PSB, including externalizing behavior problems (e.g., ADHD, oppositional or aggressive behavior), internalizing problems (e.g., post-traumatic stress disorder symptoms, depression or anxiety), developmental and learning problems, and adverse environments (e.g., physical abuse, neglect or exposure to violence)*
- *Include Trauma Symptom Assessments for Children*

5. Assessing sexual behavior and contributing factors

- *Clear behavioral description of the sexual behaviors involved, when they began, how frequently they occur, and how and whether they have progressed or changed over time is a core assessment component*
- *Determining the extent to which the pattern of PSB is self-focused, other-directed, planned, aggressive or coercive*
- *The sexual behavior history should include attention to prior efforts or lack of efforts made by the parents or caregivers to correct the behavior, and the child response to these efforts*
- *The Child Sexual Behavior Inventory-III (CSBI-III; Friedrich, 1997) designed for children 2-12, measure the frequency of both common and atypical behaviors, self-focused and other focused behaviors, sexual knowledge, and level of interest, planned and aggressive sexual behaviors*
- *Child Sexual Behavior Checklist (CSBCL-2nd Revision) Johnson & Friend, 1995*
- *Weekly Behavior Report (WBR; Cohen & Mannarino, 1996a)*

6. Risk Assessment for Children under age 12

- *AIM2*
- *LA-SAAT*
- *MEGA*

7. Good child assessment reports often include explicit statements to guard against inappropriate use of the report long after its validity has expired.

8. Assessment should include some estimate of how any intervention recommendations or decisions might negatively affect the child."

[Sourced from The Report of the Task Force on Children with Sexual Behavior Problems, ATSA, 2006.]

Appendix B: Outline of current recommended treatment modalities and content for children under age 12

"PSB-focused CBT approaches that include parent/caregiver involvement:

- *Blended CBT treatments targeting both traumatic stress symptoms and PSB*
- *Parental involvement: joint dyadic sessions, regular parent collateral sessions, and in-home or family therapy modalities*

Group-based treatment for children:

- *Group formats described in the clinical and research literatures have not segregated children with PSB by gender and can accommodate both boys and girls of comparable ages*

Co-morbid cases where PSB is a secondary focus:

- *Traumatic Stress Symptoms: TF-CBT*
- *Early Childhood Disruptive Behavior Problems*
    - *Parent-Child Interaction Therapy (Breston & Eyberg, 1998)*
    - *The Incredible Years (Webster-Stratton, 2005)*
    - *Barkley's Defiant Child Protocol (Barkley & Benton, 1998)*
    - *Triple-P Program (Sanders, Conn & Markie-Dadds, 2003)*
- *Insecure Attachment*
    - *Emphasize parental sensitivity (Bakersman-Kranenburg, et al. 2003)*

PSB Focused Treatment Components—For Children Include

1. Identifying, recognizing the inappropriateness of, and apologizing for rule-violating sexual behaviors that occurred. This component is often omitted with very young children (e.g., under 7 years). This component should not be misinterpreted as a requirement that the child admit or acknowledge past behaviors as a pre-requisite for treatment
2. Learning and practicing basic, simple rules about sexual behavior and physical boundaries. Teaching sexual behavior and boundary rules should not imply that all forms of human sexuality, touching or close contact are wrong and lead to trouble. It may be important to emphasize which behaviors are acceptable and distinguish these from which behaviors are against the rules
3. Age-appropriate sex education

4. Coping and self-control strategies. This may include teaching relaxation skills, problem solving skills, or routines to encourage stopping and thinking before acting
5. Basic sexual abuse prevention/safety skills
6. Social skills

Components for Parents or Caregivers Include

1. Developing a safety plan
2. Information about sexual development, normal sexual play and exploration, and how these differ from PSB
3. Strategies to encourage children to follow privacy and sexual behavior rules
4. Factors that contribute to the development and maintenance of PSB and how to maintain an environment that is not overly sexually stimulating for the child
5. Sex education and how to listen and talk with children about sexual matters
6. Parenting strategies to build positive relationships with children and address behavior problems
7. Supporting children's use of the self-control strategies they have learned
8. Relationship building and appropriate physical affection with children
9. How to guide the child toward positive peer groups"

[Sourced from The Report of the Task Force on Children with Sexual Behavior Problems, ATSA, 2006.]

Appendix C: Supervision and monitoring of children under age 12 with PSB

"1. It is important to develop, implement and communicate supervision and monitoring plans for children with sexual behavior problems across systems.

2. Most children with PSB can remain in their home or foster home with other children without problematic sexual behavior. However, children who continue to exhibit highly intrusive or aggressive sexual behavior despite treatment and close supervision should not live with other young children until this behavior is resolved.

3. Most children can attend public schools and participate in school activates without jeopardizing the safety of other students. Children with serious, aggressive sexual behaviors may need a more restrictive educational environment.

4. A behavioral plan to decrease the child's problematic sexual behaviors should be developed with full participation of the caregivers and the child. The plan requires full participation of both and must be clear regarding acceptable behaviors.

5. Depending on the level and type of sexual behavior problems, the child may need to be supervised while with other children; not sleep in the same room with another child; not sleep in the same bed with other children or adults at any time; not be left to care for other children, even for a short time; all bathroom activities should be done separately from other children and adults; adults and children should not walk around without clothes on; caregivers should not have sexual intercourse when the child is in the home; and if a child who has previously engaged in sexually inappropriate behavior is living in a home with other children the other children should be told. Motion detectors and buzzers can be used if needed to alert caregivers of the child leaving the bedroom at night.

6. The home environment must provide a healthy sexual environment and encourage healthy boundaries by developing healthy rules.

7. Some children with sexual behavior problems will require notification of the school and after care providers. All professionals working with the child should be in monthly communication to assure that there is a coordinated treatment plan on which all team members agree.

8. All decisions and goals should be made with the child, whenever possible.

9. If the child with PSB remains at home, it is strongly advised to have an open CPS case with authority. When parents and children have to go to therapy without the authoritative incentive of CPS or probation, attendance may be sporadic or nonexistent.

10. Some children with PSB are put on probation. If the child is on probation the terms of the probation should be understood by all of the members of the treatment team."

[Sourced from: TDMHSAS BEST PRACTICE GUIDELINES, *Children with Sexual Behavior Problems*, Workgroup Members: Melissa L. Hoffman, PhD, University of Tennessee Center of Excellence for Children in State Custody – Chairperson; Bonnie Beneke, LSCW, Tennessee Chapter of Children's Advocacy Centers; Tarah M. Kuhn, PhD, Vanderbilt University; and Melissa James, LCSW, University of Tennessee Health Science Center, 2013.]

Resources

There are a multitude of free, governmental and nonprofit partners who offer free resources and training to assist schools in identifying and addressing sexual behavior in children.
The following documents are downloadable from the Colorado Department of Public Safety:

- School Safety Resource Center (CSSRC): Resources for Child Sexual Abuse and Assault Prevention. This publication, updated annually, provides content and contact information for programs designed to prevent child sexual abuse, sometimes as a part of programs which implement social-emotional learning, safeguard behavioral and public health, address antisocial/aggressive behaviors, substance misuse, family conflict, and even poor school/community attachment. Programs containing these elements, especially those which have demonstrated proven outcomes through evidence-based means, may effectively prevent sexual abuse. The guide describes proven evidence-based programs, as well as evidence informed or "best practice" programs. The guide also provides schools with information to prevent human trafficking, grant-funded sexual health programs, and contacts for government programs offered by the various state departments. Last, the guide provides descriptions of various statewide coalitions, children's advocacy centers, and additional resources.
- The Division of Criminal Justice: (Sex Offender Management Board) collaborated with the Colorado Department of Education (CDE) and a group of stakeholders to publish the Reference Guide for School Personnel Concerning Juveniles Who Have Committed Sexually Abusive and Offending Behavior. This guide is designed to provide information to school administrators, teachers, and other staff regarding the supervision of juveniles who have committed sexual offenses. The document provides best practice guidelines related to the responsibilities of school administration in developing a safe and inclusive environment and school community. The goal of this guide is to build a foundation for safety within the school community; to respond to the individual needs of the victim(s) and his/her family; and address through supervision and management the needs of the juvenile who committed the sexual offense.
- The Division of Criminal Justice (Domestic Violence/Sex Offender Management Boards) and a multidisciplinary group of professionals recognized the gap in services for treatment of youth who use abusive, harmful, and/or illegal behaviors in the context of relationship violence. In an effort to promote healthy relationships and reduce abuse in dating relationships during adolescence, the group created a set of guidelines to guide the responses of the education system, criminal justice system, survivor advocacy, clinical interventions, and human services. Best Practice Guidelines for Working with Youth who Engage in Relationship Abuse.

Additional resources:

Childhood Sexuality: A Guide for Parents, Gail Ryan & Joanne Blum (1994), Kempe Children's Center University of Colorado Health Sciences Center Department of Pediatrics

Stop It Now! Prevention Tools, accessed at www.StopItNow.org

What is Problematic Sexual Behavior? National Center on the Sexual Behavior of Youth, accessed at www.ncsby.org

The Kempe Center for the Prevention and Treatment of Child Abuse and Neglect
https://medschool.cuanschutz.edu/pediatrics/sections/child-abuse-and-neglect-kempe-center

Tennyson Center for Children
https://www.tennysoncenter.org/about-us/

LA-SAAT Link: http://www.philrich.net/risk-assessment-instruments.html

MEGA Link: https://www.mega-miccio-fonseca.com/

Link for ACE Administration and Questionnaire: https://www.chcs.org/media/TA-Tool-Screening-for-ACEs-and-Trauma_020619.pdf

TSCYC, Briere, 2005 Link: https://www.parinc.com/products/pkey/463

CSBI, Friedrich, 1997 Link: https://www.nctsn.org/measures/child-sexual-behavior-inventory

Toni Cavanaugh Assessing Children's Sexual Behaviors: The Child Sexual Behavior Checklist (CSBCL) Second Revision