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A Non-Clinical Referral Tool to Help Identify Problematic Child Sexual Behavior: Development, Training, and Initial User Feedback

Jill A. Schulte, Mandie K. Boone, Keith R. Aronson, and Daniel F. Perkins

Pennsylvania State University, University Park, PA, USA

ABSTRACT

Early identification of children and youth who engage in problematic sexual behavior is important for all parties involved, such as children who exhibit and are impacted by the behavior. There are several reliable and valid identification tools that can be used to recognize problematic sexual behavior in children and youth (PSB-CY) in clinical practice; however, professionals who work with children in non-clinical settings (i.e., child development centers, youth programs, and schools) often have limited resources and tools when they encounter PSB-CY. This paper describes the development, content, and user feedback of a referral tool (RT) that was designed to help identify incidents of PSB-CY for use with military agencies and schools. Specifically, the RT was designed to help professionals, who may have observed or who may have been made aware of sexual behaviors in children and youth, organize their observations of the behavior in alignment with evidence-based information about PSB-CY and consistently document these occurrences. The RT guides users in determining if the observed behavior is normative, cautionary, or problematic and promotes informed decisions about whether the behavior needs to be referred to those who have experience using clinical tools for further review and the identification of next steps for supporting the children and families involved. Early adopters provided feedback on the use of the RT. The feedback suggested that the tool was user-friendly, understandable, and helpful as they made objective decisions about how to identify and handle referrals of PSB-CY.

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CONTACT Jill A. Schulte jas1070@psu.edu Clearinghouse for Military Family Readiness at Penn State University, 402 Marion Place, University Park, PA 16802, USA

Author note: Jill A. Schulte, Social Science Research Institute, Clearinghouse for Military Family Readiness, The Pennsylvania State University; University Park, PA; Mandie K. Boone, Social Science Research Institute, Clearinghouse for Military Family Readiness, The Pennsylvania State University; University Park, PA; Keith R. Aronson, Social Science Research Institute, Clearinghouse for Military Family Readiness, The Pennsylvania State University; University Park, PA; Daniel F. Perkins, Department of Agricultural Economics, Sociology, and Education, Clearinghouse for Military Family Readiness, The Pennsylvania State University; University Park, PA.

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Problematic sexual behavior in children and youth (PSB-CY) are actions that are developmentally rare, involve sexual body parts, and may be harmful to children or youth directly involved in incidents, as well as to others who may witness PSB-CY (Chaffin et al., 2008). Although not a diagnosable condition, PSB-CY involves a broad spectrum of sexual behavior that may warrant clinical attention (Elkovitch et al., 2009). The prevalence of PSB-CY is not known. Approximately one-quarter of cases handled by Child Advocacy Centers involve children and youth sexually acting out against another minor (National Childrens Alliance, 2015; Snyder, 2000). A report by the Association for the Treatment of Sexual Abusers (2017) found that 5% of adolescent males and approximately 1% of adolescent females engaged in sexual offenses. One-third of these sexual offenses were committed against minors.

PSB-CY is harmful to those impacted by the behavior (Allen et al., 2014) as they can exhibit somatic and psychological symptoms, including feeling sick to the stomach, somatic pains, elevated anxiety, depression, and trauma symptoms (Allen et al., 2014). More serious symptomology, such as trauma-related symptoms, are associated with increasing levels of aggression, coercion, physical harm, and intrusion (Mesman et al., 2019). PSB-CY is also harmful to those who exhibit the behavior (Bonner et al., 2001; Lévesque et al., 2010) as they can be socially isolated and rejected and may face school, parental, and legal consequences in the juvenile justice system (Lévesque et al., 2010; Mesman et al., 2019).

Children who engage in PSB-CY are diverse in presentation, varying by age, sex/gender, and self versus other focused behavior (Larsson & Svedin, 2002). A study conducted by Szanto et al. (2012), utilized the Child and Adolescent Needs and Strengths (CANS) to assess the correlation of prior childhood truama and exhibiting problematic sexual behavior with a sample of 5,976 children aged 5–18. The study found that male and female children engage in PSB-CY in equal proportion; however, girls are more likely to engage in problematic behaviors in pre-school, while boys exhibit more aggressive kinds of behavior. Aggression among boys increases with age, and boys appear to have higher rates of comorbid mental health problems such as oppositionality, conduct problems, inattention and hyperactivity, impulsivity, poor social connections, and significant exposure to adverse childhood experiences such a neglect and physical, sexual, and psychological violence (Chaffin et al., 2008; Elkovitch et al., 2009).

Identifying children who engage in PSB-CY and providing them with early interventions appear to decrease or eliminate the behavior as well as address any trauma, with interventions that focus on parenting and behavior management being most effective (Bonner et al., 2001; Carpentier et al., 2006). Cognitive Behavior Therapy (CBT) has been found to reduce occurrences of PSB-CY (Allen, 2018). A randomized trial that consisted of 135 children ages 5–12 that compared a 12 session CBT group program to group play found that

the CBT group had significantly less future sexual offenses at a 10-year follow-up (Carpentier et al., 2006). There is also evidence that most adolescents who engage in sexually abusive behavior do not repeat it (ATSA, 2017).

There are a number of predictors of PSB-CY that exist such as child social immaturity, experience of maltreatment, sexual abuse victimization, externalizing behavior, and exposure to domestic violence, sexually explicit behaviors and materials (e.g., pornography), and family adversity (Dong et al., 2003; Friedrich et al., 2003). Previous studies have shown that children with sexual abuse histories have higher rates of PSB-CY than children without such a history (Cosentino et al., 1995; Friedrich et al., 1997). However, the vast majority of children who are sexually abused will not engage in PSB-CY (Kendall-Tackett et al., 1993). One study found that sexual abuse alone was not the main factor associated with sexually intrusive behaviors, but sexual abuse that consisted of earlier, longer, and more serious abuse victimization was associated with PSB-CY (Friedrich et al., 2003). Children with no known history of sexual abuse may also engage in PSB-CY (Bonner et al., 1999, 2001; Friedrich, 1993; Friedrich et al., 2005; Silovsky & Niec, 2002). The study conducted by Friedrich et al. (2003) also found that family income; life stressors; child social incompetence; and exposure to maltreatment, and domestic violence were significant predictors of sexually intrusive behaviors. Those who experienced sexual abuse typically endured other adverse childhood experiences (e.g., physical abuse, emotional abuse), and these may also contribute to the engagement in PSB-CY (Dong et al., 2003).

Classifications of child sexual behavior

Children engage in a range of sexual behaviors. Normative or common sexual behaviors occur often and without negative consequences to self or others during particular developmental stages (Friedrich et al., 1991, 1998). For example, infants begin to touch their bodies, including genitalia, within months of birth (Mesman et al., 2019). In normative samples, young children tend to display limited sexual behaviors, such as being nude, looking at others who are nude, crossing physical boundaries, and touching their own sexual body parts at home and in public (Friedrich et al., 1998; Larsson & Svedin, 2002). Between the ages of 5 and 7 years, normative behaviors include kissing, holding hands, and looking at nude pictures. Among children 10–12 years, normative behaviors include masturbating, touching genitals in private, kissing, holding hands, sexual games, and increased thoughts about sex (Friedrich et al., 1992; Schoentjes et al., 1999). As children reach early adolescence and before reaching puberty, sexual behaviors typically decrease (Friedrich et al., 1997, 1998); however, there may be an increase in some sexual behaviors such as watching nudity on television and exhibiting an

increased interest in the opposite sex (Friedrich et al., 1998). In addition, children, especially girls, may display shyness in being naked (Silovsky & Swisher, 2008).

Sexual play is also a normative part of adolescent interpersonal behavior and sexual development. A majority of high-school seniors reported having engaged in a mutual sexual experience with another child before the age of 13, and the majority reported that the experience was with a same-aged peer (Larsson & Svedin, 2002). A majority of undergraduate college students reported at least one sexual experience with another youth during their adolescence (Haugaard, 1996), and half of undergraduate college women reported engaging in sexual play with others of a similar age (Lamb & Coakley, 1993). Sexual behaviors typically occur between children who know each other and are of similar chronological or developmental ages (Chaffin et al., 2008). Normative sexual behavior is mutual and does not result in problems for self or others, there is also an absence of bribes or threats, and coercion or force are not used (Johnson, 2002).

There is also a range of behaviors that are described as cautionary, concerning, of concern, and less common. These classifications indicate that there is a range of sexual behaviors that, while less common than those seen in normative behavior, do not reach the level of PSB-CY. When these behaviors occur, they should be examined closely and addressed thoughtfully by caring adults (Chaffin et al., 2008). For example, some cautionary sexual behaviors among 2- to 4-year-old children include masturbating, in public or private, continuing to touch their own genital after adult redirection and beyond developmental expectation; touching adults' or other children's genitalia; sexual play with dolls; tongue kissing; undressing in public; and having frequent erections. Among children ages 5 to 9, some cautionary behaviors include kissing and hugging unfamiliar adults or children, touching other children's genitalia, rubbing their own genitalia against others after adult redirection and beyond developmental age expectations, and frequently using sexual language that makes other children uncomfortable. Among children 10 to 12, cautionary behaviors generally include those from previous age groups but further include simulating foreplay or intercourse with peers while clothed, discussing getting a sexually transmitted disease, taking nude pictures of oneself, and exchanging sexual content via cell phones or the internet. Among those youth who are 13–18 years of age, cautionary behaviors include being preoccupied with or anxious about sex, spying on others who are nude or engaged in sexual activities, and engaging in frequent sexual relationships about which they feel uncomfortable.

Finally, there are behaviors that are described as problematic, severe, very concerning, and rarely normal. These sexual behaviors go beyond the normative and cautionary ones described above, are rarely displayed, and have negative consequences to self or others. These behaviors can be interpersonal or self-focused and are not necessarily sexually motivated or related to sexual

gratification (Silovsky & Swisher, 2008). PSB-CY includes exposing or touching one's own or another's genitals repeatedly and/or in public, various forms of vaginal or rectal penetration, attempted or actual oral sex, forcing other children into sexual acts, emulating intercourse with self, others, or dolls, trying to undress others against their will, and trying to fondle animals or dolls in a sexual way (Friedrich et al., 1998; Schoentjes et al., 1999). PSB-CY typically continues despite parental efforts to stop the behavior, and children who engage in PSB-CY may become frustrated or angry when an adult intervenes. PSB-CY is preoccupying (Hornor, 2004).

Important considerations in identifying PSB-CY

There are several important factors to consider when making classifications about PSB-CY (Chaffin et al., 2008) including the frequency of the behavior, increasing preoccupation, whether the child responds to redirection from adults, and behavioral stability over time. Sexual behavior in children is considered problematic when it occurs at a greater frequency than is typically seen among those of a similar age (Chaffin et al., 2008; Lucier-Greer et al., 2018; Silovsky & Niec, 2002; Silovsky & Swisher, 2008), and frequency is often associated with the severity of the behavior (Johnson, 2004). The length of time that sexual behaviors have happened is important information as sexual behaviors that occur at an earlier age, than would be developmentally expected, are concerning (Chaffin et al., 2008; Lucier-Greer et al., 2018; Silovsky & Niec, 2002; Silovsky & Swisher, 2008). Determining the frequency and timing of these behaviors is not always easy because many concerning behaviors are never observed or reported.

Key concerns in determining the seriousness of PSB-CY include: (a) age and developmental age and power differences of the children involved; (b) the use of physical force, intimidation, or physical/emotional coercion; (c) any emotional distress or somatic symptoms displayed by the child(ren) impacted; (d) if the behavior interferes with the child(ren)'s social or emotional development; (e) sexual behaviors that are not responsive to redirection and (f) if the behavior causes physical injury (Johnson, 2004; Mesman et al., 2019). Behaviors that are indicative of PSB-CY that involve asking others to engage in sex acts are particularly concerning as are behaviors involving aggression, coercion, threats, force, and/or intimidation (Mesman et al., 2019).

In sum, PSB-CY frequently involves coercion, is highly intrusive, is preoccupying, occurs between children of disparate chronological or developmental ages, occurs frequently, and/or is developmentally inappropriate. PSB-CY can also be identified when behavior is planned, or given forethought, rather than when it is spontaneous. In addition, PSB-CY tends to be resistant to adult

intervention and requires focused intervention. Children engaging in PSB-CY come from a variety of family environments and varied developmental experiences.

Identifying PSB-CY in non-clinical settings

The identification of children exhibiting PSB-CY often begins in non-clinical settings (McKibbin & Humphreys, 2021). PSB-CY is often first observed by non-clinicians who are not professionally trained or provided with resources or tools to accurately identify concerning sexual behaviors (e.g., teachers, school administrators, parents, neighbors). Non-clinicians have little to no training in relevant fields (McKibbin & Humphreys, 2021). Also, significant stigma around sexuality and a discomfort in confronting these issues among non-clinically trained individuals often exist (Ey et al., 2017). Little is known about how to help non-clinicians identify possible occurrences of PSB-CY, and virtually no resources are available to assist them in referring the behavior to appropriate agencies that are trained to handle these types of behaviors.

Department of defense response to PSB-CY

In response to a noted increase in the reporting of PSB-CY within Department of Defense (DoD) Educational Activity (DoDEA) schools and Child Development and Youth Programs (CD/YP) on military installations and a lack of clarity regarding how to handle these situations, the John S. McCain National Defense Authorization Act John (2019) was passed into law which required the military to develop a policy on addressing allegations of PSB-CY. The DoD's Family Advocacy Program (FAP) became the central organization in handling reports of PSB-CY. FAP was established to prevent and respond to reports of child abuse, child neglect, child problematic sexual behavior, and domestic abuse and violence in military families. FAP managers or supervisors were further mandated to review any report of PSB-CY and identify whether to engage the FAP multi-disciplinary team (MDT) to review these reports and discuss next steps for assisting the children and families involved. The MDT examines incidents of PSB-CY to determine where and when the behavior took place, identify the exhibiting and impacted children, and verify the circumstances surrounding the behavior. The MDT also provides recommendations and referrals for treatment or other needed interventions. The military also formulated a coordinated approach for assisting those impacted by and exhibiting PSB-CY, and referring affected parties to appropriate support/treatment.

The DoD Military Community Advocacy Child and Youth Office established a team of experts who developed policy and procedures for a coordinated community response system for PSB-CY. This system supports children and families who are impacted by and who exhibit PSB-CY, address

safety needs, and limit any ongoing risks to the family and community. Part of this effort was to create a referral tool to help non-clinical supervisors, directors, and other professionals, working in DoDEA schools and CD/YP, identify occurrences of PSB-CY and ensure appropriate referrals reached FAP.

The PSB-CY non-clinical referral tool

The PSB-CY Non-Clinical Referral Tool (RT) was developed to (a) help identify occurrences of PSB-CY; (b) de-stigmatize child sexual behaviors; (c) support FAP in providing DoDEA and CD/YP personnel with consultation support and/or referrals; (d) provide a framework for professionals associated with DoDEA and CD/YP, while serving in supervisory roles, in order to make appropriate well-informed decisions about handling PSB-CY; (e) support FAP in assisting with PSB-CY referrals from a range of other sources such as parents and law enforcement; and (e) support and encourage consultations with the FAP MDTs. One essential aim of the RT was to increase non-clinical staff members' understanding that a range of child and youth sexual behaviors exists, and many of these behaviors are not indicative of a problem. The RT was not designed to determine if a child's or youth's behavior is illegal. However, if the MDT has concerns that a behavior is illegal, the appropriate legal agencies should be consulted based on the relevant statutes of each state. The purpose of the current study was to describe the processes and procedures used to develop the RT, training in its use, and feedback from early adopters of the RT.

Method

Participants

Participants were professionals from DoDEA, CD/YP, and FAP, in supervisory or PSB-CY-specific roles from pilot-test sites who received training on the RT and were asked to provide feedback on using the RT at their locations.

Procedures

Development and refinement of the RT

The development of the RT unfolded using several steps (see Figure 1). First, an extensive review of the literature on the topics of normative and non-normative sexual behavior in children and youth was conducted which was used for identifying PSB-CY were reviewed (see Table 1; American Academy of Pediatrics, 2016; Barnett et al., 2017; Bonner et al., 2001; Chaffin et al., 2008; DeLamater & Friedrich, 2002; Friedrich et al., 1991; Gil, 1993; Kendall-Tackett et al., 1993; Gordon & Schroeder, 2013; Human Rights Watch, 2013; Johnson, 2013, 2015; Kaeser et al., 2000; Kellogg, 2009; Lamb & Coakley, 1993, Araji, 1997;

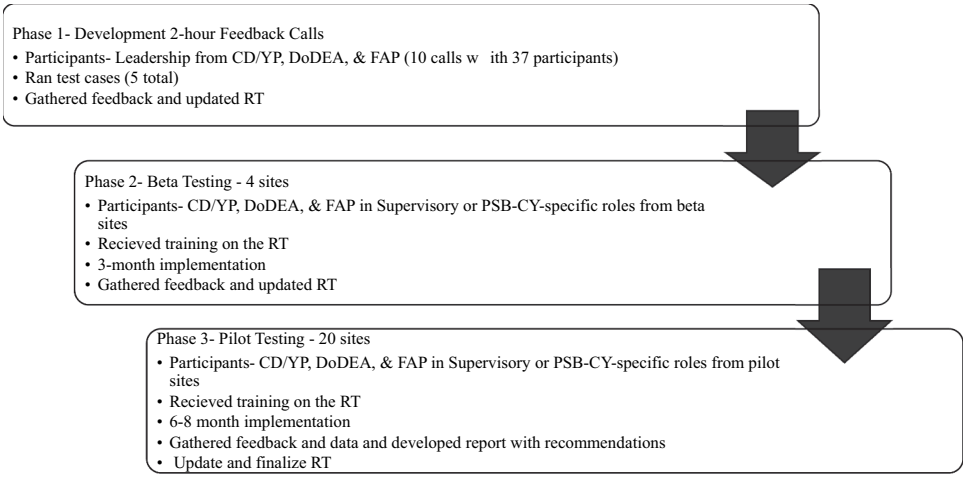

Figure 1. Testing and quality improvement phases of referral tool (RT) project.

Table 1. Nomenclatures used by different organizations to describe child and youth sexual behavior.

Name	Age	Categories Utilized	Citations
Military Reach (MR)	0–6 5–8 6–12 13–14	• Normative • Cautionary • Problematic • Severe	Friedrich et al., (1998); Kaeser et al., (2000); Silovsky & Niec (2002); Chaffin et al., (2008); Elkovitch et al., (2009); Kellogg (2009); Lévesque et al., (2012); Human Rights Watch (2013); Lucier-Greer et al., (2018); Russell & Marsh (2018)
National Center on Sexual Behavior of Youth (NCSBY)	2–6 7–12	• Common • Infrequent	(Bonner et al., 2001; DeLamater & Friedrich, 2002; Gordon & Schroeder, 2013; Johnson, 2015; Silovsky & Bonner, 2003)
Centre Against Sexual Assault & Family Violence (CASAFV)	0–4 5–9 9–12 13–18	• Age Appropriate • Concerning • Very Concerning	Ryan (2000); Johnson (2015); Barnett et al., (2017)
The Provincial Child Sexual Abuse Advisory Committee (PCSAAC)	0–5 5–10	• Natural and Healthy • Of Concern • Seek Professional Help	Larsson & Svedin (2002); National Child Traumatic Stress Network (2009); Herman-Giddens et al., (2012); Johnson (2013)
American Family Physician	2–5 6–9 10–12	• More Common • Less Common	Larsson & Svedin (2002)
American Academy of Pediatrics	2–6	• Normal/ Common Behaviors • Less Common Normal Behaviors • Uncommon Behaviors in Normal Children • Rarely Normal	American Academy of Pediatrics (2016)
Stop It Now	0–5 6–8 9–12 13–16	• Common • Uncommon	Wurtele (2009)

Hall et al., 1998; Pithers et al., 1998; Larsson & Svedin, 2002; Lévesque et al., 2012; Lucier-Greer et al., 2018; Russell & Marsh, 2018; Ryan, 2000; Silovsky & Bonner, 2003; Silovsky & Niec, 2002; Wurtele, 2009).

Next, the research team consulted with experts and professionals and organizations in the field, such as the National Center on the Sexual Behavior of Youth, to learn about new developments and important topics regarding PSB-CY. After completing numerous reviews of various iterations of the RT, individuals from the MCA CYA Office, DoDEA, CD/YP, and FAP provided input and edits to the PSB-CY RT. The PSB-CY RT was finalized and ready to be utilized with the study participants. The version used in the pilot test is described below.

Measures

The PSB-CY RT is a new measure designed to assist non-clinicians (i.e., supervisors or directors) in making decisions about whether an incident of PSB-CY has occurred and whether it should be referred to FAP for possible consideration by an MDT. Part 1 of the RT gathers information on the children involved in an incident and details related to the incident that was observed. Question 1 asks for the demographics (e.g., sex, chronological age, grade) of the exhibiting and impacted children involved in the incident. While no personal identifying information is recorded, the RT asks to indicate if the children involved have an educational support plan, because disability status makes children and youth more susceptible to PSB-CY and awareness and understanding of disabilities can be important when assessing and providing treatment for PSB-CY (Mussack, 2006). The next set of questions gather information on what behavior or behaviors were exhibited, the location where the behavior occurred, who observed or was made aware of the behavior, whether adult redirection was provided, and any noticeable reactions by the exhibiting or impacted child(ren). Part 1 also addresses the frequency of the behavior(s) exhibited or asks if past sexual behaviors had occurred. The RT includes the sexual behaviors guide (SBG), which helps the professional determine whether the behavior exhibited is normative, cautionary, or problematic based on chronological age of the exhibiting child. The SBG was created based on the review of research literature and publicly available resources related to PSB-CY and is divided into four chronological age ranges (i.e., 2–4 years, 5–9 years, 10–12 years, and 13–18 years). Each age range lists behaviors that are identified as normative "common," cautionary "less common," and problematic "uncommon." The determination of whether the children involved were at similar developmental ages is also found in Part 1. If any of the factors noted in Part 1 are not normative, the user is directed to complete Part 2 of the RT.

Part 2 includes sections 2A and 2B. Section 2A is only completed if the incident involved more than one child and includes eight questions that help the user determine the severity of the behavior (i.e., normative, cautionary, or problematic), and whether the behavior should be referred to FAP, and the MDT should be engaged to help address the behavior. The first question asks, "Does the behavior (s) fall under the *Cautionary* Sexual Behaviors Guide for exhibiting the child's chronological age?" A yes to this question is color coded with yellow, which means cautionary. The second question asks, "Does the behavior (s) fall under the *Problematic* sexual behaviors guide for exhibiting the child's chronological age?" A yes answer is color coded red, meaning problematic. Question 3 is used to determine if there was a potential power differential in which the impacted child was taken advantage of as a function of developmental delays. Power differentials occur when there is a large developmental and/or chronological age gap between the youth involved. Questions 4–7 establish whether the behavior persisted despite adult redirection, if the redirection was met with anger or irritation, whether there was physical aggression or force used by the child engaged in the behavior, and whether emotional coercion or intimidation was used. Finally, question 8 asks if child(ren) impacted by the behavior displayed emotional distress and/or somatic symptoms after the incident.

After questions 1–8 have been completed, instructions on next steps are provided. An answer "yes" to question 1, 3 or 4 results in a yellow/cautionary outcome, which indicates that a consult with FAP is necessary. A "yes" answer to 2, 5, 6, 7, or 8 results in a red/problematic outcome, which indicates that a referral to FAP is necessary and automatic engagement of the MDT must occur. FAP, then, reviews the information with the referral source and provides guidance on next steps for engagement with the MDT. If the behavior falls in the cautionary or problematic category, several protocol steps are executed. These steps include following processes and procedures for addressing safety concerns for all children; completing the DoDEA and CD/YP documentation page that is used for internal record keeping of the referral process; following internal CD/YP and DoDEA procedures for reporting PSB-CY incidents to FAP; providing a copy of the RT to the FAP point of contact (POC); conferring with the FAP POC and relevant supervisor to discuss strategies for addressing the behavior while FAP engages the MDT; and following internal processes and procedures for notification of parents/caregivers and follow-up actions.

Part 2 section 2B is completed only if the incident involved one child (i.e., there are no other observing or impacted children) and includes four questions. The first two questions are the same as the questions in Section 2A and ask, "Does the behavior (s) fall under the *Cautionary* Sexual Behaviors Guide for exhibiting the child's chronological age?" and "Does the behavior (s) fall under the *Problematic* sexual behaviors guide for exhibiting the child's

chronological age?" The questions related to adult redirection and whether that redirection was met with anger or irritation are also found in this section. The response selections are again color coded to indicate a cautionary or problematic behavior. Red indicates a problematic outcome, and a referral to FAP for DoDEA and CD/YP personnel is required. Yellow indicates a cautionary outcome, and a consult with FAP for DoDEA and CD/YP personnel is required. A response of "no" for all four questions indicates the behavior should be considered normative. The user then follows the same protocol next steps listed in the section above.

Training in the use of the RT

Training was provided to supervisors and directors from 20 pilot sites across all four Service branches. The training lasted 2.5 hours and was provided virtually. The first part of the training included an overview of the research on the categories of sexual behaviors exhibited by children and youth and a review of all of the resources and additional trainings related to PSB-CY available to supervisors and directors from DoDEA, CD/YP, and FAP. The second part of the training centered on the use of the RT. Each section was described and three to five test cases were reviewed to demonstrate how to complete the RT. Test cases were real examples; however, the specific information (e.g. age range, Service branch, location) was altered to protect anonymity. The participants were asked to use the test cases to assess their understanding of the elements of PSB-CY and ability to use the RT correctly. Finally, a review of the RT training and implementation support website was provided. The implementation support website houses a learning module on the implementation of the RT and can be used as refresher training. The implementation support site also houses information on available resources for professionals, frequently asked questions related to completing the RT and the PSB-CY referral process, and contact us page where users of the RT can submit questions to the research team they have regarding implementation of the RT. Throughout the training, questions were encouraged and answered.

After training, users were encouraged to call implementation coaches from the research team to help them answer questions and think through next steps. Proactive implementation support calls were also made to check in with users, encourage questions, discuss challenges, and take advantage of lessons learned by other users (Baumann et al., 2016; Brownson et al., 2017).

User feedback

In this project, obtaining feedback from the users of the RT was essential to help ensure that the RT was a good fit for the "real world," and readability, efficiency, and user ease were assessed. To gather feedback, semi-structured

interviews were conducted with a subset of FAP, CD/YP, and DoDEA personnel who had used the RT during pilot testing. User feedback centered on respondents' perceptions of the RT's usability and feasibility and their questions regarding the implementation of the RT and handling of PSB-CY referrals. Additional questions focused on barriers encountered to using the RT, lack of clarity on how to use the RT and the possible need for more training, what would help users gain confidence and skill in implementing the RT, lessons learned, shortcomings of the RT, and any other feedback that could be used to improve the usability of the RT.

Results

Training

A total of 32 trainings were completed. A total of 1,038 participants were trained. Out of the 1,038 participants trained, 289 worked with FAP, 348 were from CD/YP, and 189 were from DoDEA schools. Eighty-one were from diverse groups of personnel not designated as RT users (e.g., criminal investigative personnel, school liaison), and they also attended the training.

User feedback

FAP users of the RT ($n = 43$) were asked six questions. The research team conducted 23 feedback phone calls with the 43 FAP participants. Most of the feedback calls included multiple FAP personnel. Users were asked if the RT had been useful in handling PSB-CY referrals. All participants reported that using the RT was useful, and it helped them determine what category the behavior fell under (i.e., normative, cautionary, problematic) and establish a clear path for next steps. Users also appreciated that the RT provided an objective framework and removed a lot of guess work for them as they identified potential PSB-CY.

Users were also asked if they encountered any barriers to implementing the RT. In most cases, users indicated that leadership involvement and consistency of leadership communication, buy-in, and support was essential as they implemented the RT. Others were concerned that more information was needed regarding how to implement and conduct the MDT and who to involve as part of the MDT. In addition, users suggested that some of the questions should be rephrased and that case examples to assist with the appropriate classification of behaviors in the normative, cautionary, and problematic categories should be provided. Finally, some users felt that they were not qualified to complete the RT and wanted more training.

Users were then asked if any parts of the RT were unclear. The RT was described as initially overwhelming, but users indicated it quickly became easy

to use after practice. There was some confusion about how to determine the frequency of problematic behavior. Additional clarification was built into the training, and Question 3 in Part 1 that addresses frequency was split into three parts to address this confusion. Users were also asked if there was anything that helped them gain confidence in using the RT. Users noted the check-in calls, training, and support website as being particularly helpful. Finally, users were asked if there was additional information the RT could include to help them in their assessments. Suggestions included highlight the most important parts of the RT, add a question regarding where the incident took place, include FAP contact information on the RT, provide instructions on the form as to whom should be contacted throughout the referral process, add an area that addresses immediate safety concerns and determine if a safety plan has been put in place, and insert a definition of coercion. Based on the feedback and data provided throughout the pilot-testing process, updates and clarifications were made to the RT.

Discussion

Accurate identification of PSB-CY is critical, so children are safe, and those who exhibit and are impacted by these behaviors, and their families, receive the treatment and support they need. However, non-clinical professionals (e.g., teachers, child development center workers) who often observe PSB-CY have had limited or no resources to use when making determinations as to whether PSB-CY has occurred and what next steps need to be taken to support the involved children and families. This study described the development of an RT developed to help non-clinical professionals clarify and record details related to potential PSB-CY incidents, consider factors and contexts related to these incidents in a manner that aligns with best practices, and suggest helpful next steps. Based on feedback, the RT helped users consider important factors related to concerning sexual behaviors and, ultimately, assisted in the accurate identification of PSB-CY. Thus, there is evidence, albeit limited, that the RT can help non-clinical professionals identify PSB-CY and set into motion the appropriate steps to ensure safety and provide help to those affected by PSB-CY.

Equally important is that children who exhibit normative sexual behavior are not misclassified as having engaged in PSB-CY. Children who engage in PSB-CY can be socially isolated and rejected; have school consequences such as suspensions or expulsions; and have legal consequences, including the possibility of being remanded to child juvenile justice (Lévesque et al., 2010; Mesman et al., 2019). Misclassification of PSB-CY could result in irreparable harm being done to children and families. Thus, the RT may prove useful in reducing misclassification of normative sexual behavior and prevent unintended serious harm.

While the accuracy of the RT in identifying actual cases of PSB-CY has yet to be established, it is important to note that it was developed after extensive review of the literature on PSB-CY and consultation with leaders in the field. Thus, the RT focuses on empirically supported factors to consider when determining if a particular behavior is indicative of a problem and whether referrals to experts for more in-depth analysis and follow-up are needed.

The RT was designed to be (a) used by professionals who do not have clinical training and who work in schools and child and youth serving agencies, (b) easy to use, (c) straightforward, and (d) used collaboratively among professionals with and without clinical training. Results of the study suggest that supervisors and directors who do not have clinical training and who work in schools and child and youth servicing agencies could be trained to use the RT. Based on best practices in adult education (Chugai et al., 2017), attendees completed a number of practice cases and were given time to debrief on how decisions were made.

Feedback was sought from users to allow for practical refinement of the tool. Users reported that the RT was a useful guide in helping them understand a range of sexual behaviors displayed and classify behaviors as normative, cautionary, or problematic. Users also reported that having the RT took some of the emotionality, bias, and stigma out of the process of identifying sexual behaviors. Finally, users reported that the RT framework was easy to follow, made logical sense, was straightforward to implement with practice, and led to better decisions about what to do (or not to do) in cases where sexual behaviors were exhibited.

Limitations and next steps

A significant limitation of this study, and for the field of PSB-CY in general, is the lack of current research on this topic. For example, one of the most widely used measures of child and youth sexual behavior was published in the early 1990s. Moreover, many of the studies that have defined what constitutes normative and problematic sexual behavior are decades old. Today, children and youth spend hours per day online using social media, surfing the web, and downloading or using various apps and websites. As a result, observing mainstream sexual media exposure (Coyne et al., 2019), texting sexually explicit language and images (Mori et al., 2019), watching online sexual behavior (Maas et al., 2019); and having easy access to online pornography (Herbenick et al., 2020) can be commonplace. Future studies should examine current child and youth sexual attitudes, beliefs, and behaviors, so a more accurate understanding of normative and problematic behavior can be achieved.

The current study provides information on the early stages of the RT's use in the military. The utility and accuracy of the RT are not known and will

require larger-scale evaluations of its reliability and validity. Based on the systematic user feedback collected, the RT could be a valuable tool for directors and supervisors of non-clinical frontline staff who work directly with children and youth in various settings and contexts and for those who handle PSB-CY referrals, such as child advocacy centers and schools.

While this study focused on processes and procedures within the military context, there are opportunities for the use of the RT in other settings. For example, school districts and child care organizations could adopt the use of the RT, so teachers, staff, and administrators who observe behaviors that concern them can have an objective and comprehensive way to report their concerns. School districts typically have interdisciplinary teams for children who are struggling in school (Crow & Pounder, 2000). These interdisciplinary teams could review RTs and make thoughtful decisions about what to do to best serve their students.

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Notes on contributors

Jill Schulte, M.Ed., is a Research Program Manager at The Pennsylvania State University for the Clearinghouse for Military Family Readiness, University Park, PA. She has managed several research projects that are designed to develop, train, and evaluate evidence-informed and evidence-based programs and resources to support military professionals who work with the Family Advocacy Program.

Mandie K. Boone, B.A., is a Research and Evaluation Associate at The Pennsylvania State University for the Clearinghouse for Military Family Readiness, University Park, PA. Mandie has worked in the field of Mental Health and has worked on several research projects that support the health and well-being of our military service members and their families.

Keith R. Aronson, Ph.D., received his Ph.D. in clinical psychology from Penn State University and is the Co-Director of the Clearinghouse for Military Family Readiness and a Research Professor in the Department of Biobehavioral Health at The Pennsylvania State University,

University Park, PA. He is also the Associate Director of the Social Science Research Institute at Penn State University.

Daniel F. Perkins, Ph.D., received his Ph.D. from Michigan State University in Family and Child Ecology and is the Director and founder of the Clearinghouse for Military Family Readiness and a Professor of Family and Youth Resiliency and Policy at The Pennsylvania State University, University Park, PA. His primary research focus involves translating science into action by providing comprehensive science-based programs and technical assistance to professionals working with military and veteran families.

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