EMERGE
CENTER FOR PEDIATRIC
FAMILY DEVELOPMENT

The Effects of Mental Health Clinician Characteristics and Education on Willingness to Treat Child Problematic Sexual Behavior

Dr. Elise Hutchison, PhD, LMHC, LCPC

Emerge Center for Pediatric Family Development

CHILDREN'S JUSTICE CONFERENCE 2026 PRESENTATION

Agenda

1. Welcome & objectives

2. Background and history

3. Research study details

4. Results

5. Next steps

6. Q&A

Background & History

MY JOURNEY TREATING PSB IN SPOKANE

Clinical Experience

- Based in Spokane, WA — serving children and families through the Emerge Center for Pediatric Family Development
- Specialized in treating children ages 12 and younger who exhibit problematic sexual behavior (PSB). CBT for PSB
- Witnessed firsthand the significant gaps in access to timely and effective PSB treatment for children in the Spokane region
- Experience shaped by working directly with families navigating the challenges of finding qualified clinicians willing to treat child PSB

What Drove This Research

- Recognized a critical shortage of clinicians trained and willing to address PSB in children across the Inland Northwest
- Observed that many clinicians either refused to treat children with PSB or referred them out without an alternative provider
- Motivated to investigate the clinician-level factors — characteristics, comfort, and education — that contribute to this treatment gap
- Founded the Emerge Center to fill this gap and provide specialized, evidence-based treatment for children and families

Problematic Sexual Behavior (PSB) in Children

PSB Definition: Behaviors involving sexual body parts (i.e., genitals, anus, buttocks, or breasts) that are developmentally inappropriate or potentially harmful to themselves or others (Chaffin et al., 2008).

In the United States most child sexual abuse (CSA) is initiated by other children rather than adult pedophiles (Heiden-Rootes et al., 2017; Malvaso et al., 2019; McKibbin 2017; Shields et al., 2018; Shields et al., 2020; Short et al., 2016; Taylor et al., 2020; & Tener et al., 2019).

Although children exhibiting PSB causes the majority of CSA this issue has the least number of resources, funding, research or even acknowledgement by the public, professional and academic communities at large when compared to CSA perpetrated by adults.

This may be due to individuals personal and societal tendencies to shy away from issues that produce discomfort or unease (Heiden-Rootes et al., 2017).

Due to PSB's lack of public acknowledgement and funding children and their supports report an inability to access timely and effective treatment intervention for PSB (Belluardo-Crosby, 2011; Jenkins et al., 2020; Malvaso et al., 2019; McKibbin, 2017; Shields et al., 2020; Shields et al., 2018; Taylor et al., 2020; & Tener et al., 2019).

Mental Health Clinicians Willingness to Treat Sexual Issues

- Mental health clinicians either refer clients with PSB out or refuse to treat them without providing an alternate referral in adolescent and adult populations (Heiden-Rootes et al., 2017; Malvaso et al., 2019; McKibbin 2017; Shields et al., 2018; Shields et al., 2020; Short et al., 2016; Taylor et al., 2020; & Tener et al., 2019).

- Previous research has indicated the following factors may impact mental health clinicians' willingness to treat PSB in adolescent and adult populations (Heiden-Rootes et al., 2017; Miller, & Byers, 2008, 2010, 2012):

Differentiation of Self (DoS)

Sexual Intervention Self-Efficacy (SISE)

Sexual Comfort

Sexuality Specific Education and Training

CONTRIBUTING FACTORS

RESEARCH CONTEXT

The Gap

The academic literature has not addressed the significant issues faced by children attempting to gain effective treatment for PSB (McKibbin, 2017; & Malvaso et al., 2019).

Although literature identifies that clinicians lack willingness to treat sexual concerns in adolescents and adults, previous studies have not investigated this issue for children (ages 12 and younger), which is considered a specialized client population when PSB is concerned (Belluardo-Crosby, 2011; Jenkins et al., 2020; Shields et al., 2020; & Short et al., 2016).

Importance: Treatment of PSB in childhood shows that if children get early and effective intervention the PSB will go into full remission long-term, reducing the number of adolescents and adults who would have a need to address these concerns later in life once they have become more ingrained behaviors (Belluardo-Crosby, 2011; Jenkins et al., 2020; Malvaso et al., 2019; McKibbin, 2017; Shields et al., 2020; Shields et al., 2018; Taylor et al., 2020; & Tener et al., 2019).

A better understanding of mental health clinicians' characteristics and education related to treatment willingness of PSB in children would allow for better support of these clinicians likely increasing child access to effective and timely treatment for PSB.

Problem Statement

RESEARCH PROBLEM

Children who exhibit PSB and their families are unable to access timely and effective treatment to address their PSB symptoms. Mental Health Clinicians are not willing to effectively treat children ages 12 and younger who present to treatment to address issues of PSB.

CURRENT LITERATURE

- Mental Health Clinicians have low rates of willingness to work with any adult or adolescent with sexual concerns.
- Mental Health Clinicians either refuse to work with these clients or refer them out to other providers.
- When investigating factors that contribute to clinician willingness to treat these issues in non child populations individual clinician characteristics and lack of education and training were identified as common factors.

Conceptual Framework

Bowen's Family Systems Theory (BFST) and Differentiation of Self (DoS)

- BFST (Kerr & Bowen, 1988) provides a foundation for how individuals in relationships navigate complex emotionally charged situations such as discussing and treating PSB
- The construct of DoS (Heiden-Rootes et al., 2017) stemming from BFST, posits that individuals have a level of DoS which allows them stay either more or less emotionally regulated in the face of emotionally charged content such as during PSB treatment.
- Looking at both BFST and DoS it is possible to analyze how Individual characteristics such as independence and self-regulation in the context of a relationship, such as the one occurring in counseling, may contribute to clinicians being willing and able to provide effective PSB treatment.

Self-Efficacy and Sexual Intervention Self-Efficacy

- Bandura (1997) found that there is a causal relationship between self-efficacy and a willingness to engage in and persist at tasks.
- Evidence suggests increasing a clinicians' self-efficacy in a specialized skill such as PSB treatment may increase their interest, and willingness to use that skill set (Heppner et al., 1996; & Miller, & Byers, 2012).

Variables

EMERGE

PREDICTOR VARIABLES

Differentiation of Self (DoS)
Degree to which an individual can balance emotional with intellectual functioning and closeness with independence in relationships with others (Bowen, 1978)

Sexual Intervention Self-Efficacy (SISE)
Extent of the belief that a mental health clinician has that they are capable of performing the specific tasks of: Sex Therapy Skills, Relaying Sexual Information, Exhibiting Comfort with Sexual Topics, and Exhibiting Personal Bias with Sexuality based topics (Miller & Byers, 2008).

Sexual Comfort
A developmental task that is influenced by physiological, psychological, sociological, religious and spiritual, educational and sexual parts of the self (Graham and Smith, 1984)

Sexuality Specific Education and Training
How many sexuality specific education courses and post graduate trainings the participant has attended.

OUTCOME VARIABLE

Willingness to Treat Child Problematic Sexual Behavior
A mental health clinician accepting new clients who identify as seeking services to specifically address sexual issues (sexual problems, sexual orientation, sexual dysfunction, or sexual relationship dynamics) as well as a mental health clinicians' willful engagement in the discussion of sexual issues during the course of treatment (Harris and Hayes, 2008)

RELATIONSHIP MODEL

DoS | SISE | Sexual Comfort | Education & Training

>>> Willingness to Treat

Study Design

METHODOLOGY

Quantitative Non-Experimental Correlational Design Using Primary Survey Data

STUDY INTENT

Investigate the effects of Mental Health Clinician characteristics and education on mental health clinician willingness to treat PSB in children aged 12 and younger.

- Differentiation of Self (DoS)
- Sexual Intervention Self-Efficacy (SISE)
- Sexual Comfort
- Sexuality Specific Education & Training

PREDICTOR VARIABLES → OUTCOME: WILLINGNESS TO TREAT CHILD PSB

Research Question

RQ1

What is the extent of the combined and unique relationships between mental health clinicians' differentiation of self (DoS), sexual intervention self-efficacy, sexual comfort, and amount of sexuality specific education and training, and mental health clinicians willingness to provide treatment to children who exhibit PSB?

Participants / Sample Size

Primary Self-Report Survey Data

Quantitative data collected directly from practicing clinicians via structured survey instruments.

Population

Masters level mental health clinicians

n = 63

Inclusion Criteria

Actively practicing Masters level mental health clinicians, living in the United States and having 6 or more months of experience working with children.

Post-Hoc Power Analysis

G*Power with an alpha level of .05, an effect size (f^2) of .318 (large effect, Cohen 1988) and a sample size of 63, indicated a power of .95.

ALPHA	EFFECT SIZE (F^2)
.05	.318
SAMPLE SIZE	**POWER**
63	.95

STATISTICAL POWER 95%

Results

Multiple Linear Regression — Full Model

24.1%	4.52	.003	Moderate
VARIANCE EXPLAINED (R^2)	F-STATISTIC	P-VALUE	EFFECT SIZE

Model	R	R^2	Adjusted R^2	SE	F	df1	df2	p
1	.49	.24	.18	5.09	4.52	4	57	**.003**

NULL HYPOTHESIS REJECTED

The model was statistically significant, explaining **24.1%** (R^2=.24) of the variance of the outcome variable and represents a **moderate effect size** based on Cohen's (1988) standards. $F(4, 57) = 4.52$, $p = .003$

SIGNIFICANT SECOND REGRESSION MODEL

Results — Second Model

- Second Multiple Linear Regression Model was Significant **F(2, 59) = 8.54, p < .001**
- Explaining **22.4%** (R^2=.23) variance in the outcome variable
- Represents a **moderate effect size** based on Cohen's (1988) conventions

22.4%
VARIANCE EXPLAINED

p < .001
SIGNIFICANCE

8.54
F-STATISTIC

MODEL SUMMARY

Model	R	R^2	Adj. R^2	SE	F	df1	df2	p
1	.47	.22	.20	5.06	8.54	2	59	.001

The refined two-predictor model retained significance while achieving comparable explanatory power to the full four-predictor model (R^2=.22 vs. R^2=.24), supporting a more parsimonious explanation of clinician willingness to treat child PSB.

REGRESSION ANALYSIS

Results – Coefficients

VARIABLE	B	SE B	BETA	T	P	95% CI LL	95% CI UL
(Constant)	-4.97	6.32	—	-0.79	.44	-17.63	7.68
SISE	0.15	0.10	.20	1.42	.16	-.06	.39
Sexual Comfort	0.22	0.09	**.34**	2.43	**.02***	.04	.39

PARTIAL CORRELATIONS — VARIABLE CONTRIBUTION

1 **Sexual Comfort**

Significant positive moderate partial correlation

R **.28** P **.018**

2 **SISE**

Weak positive association; did not reach statistical significance

R **.16** P **.16**

✓ **Sexual comfort (β = .34) was the only statistically significant unique predictor of willingness to treat child PSB (p = .02)**

Results – Post-Hoc Demographic Comparisons

EXPOSURE TO CHILD PSB CASES — INDEPENDENT SAMPLES T-TEST

Statistically significant difference in willingness to treat scores between clinicians who **had been exposed** to child PSB in their practices and those who **had not**, **t(58) = 2.58, p = .012** (two-tailed).

MEAN WILLINGNESS SCORE COMPARISON

2.58	.012	+3.77
T-VALUE	P-VALUE	MEAN DIFF

INDEPENDENT SAMPLES T-TEST RESULTS

Exposed to PSB Cases	n	M	SD	t	df	p	95% CI LL	95% CI UL
✓	38	17.50	5.44	**2.58**	58	.01	.84	6.70
✗	22	13.73	5.50				—	

Results – Sexual Trauma History and Willingness to Treat

No significant difference in willingness to treat child PSB scores for clinicians with trauma history

t(61) = −0.62, p = .54 **NOT SIG.**

No significant difference in willingness scores for clinicians with a close contact history

t(61) = −0.36, p = .72 **NOT SIG.**

TABLE 1 — PERSONAL TRAUMA HISTORY

TRAUMA HISTORY	N	M	SD	T	DF	P	95% CI LL	UL
Yes	33	15.78	5.17	−0.62	61	.54	−3.72	1.97
No	30	16.63	6.11					

TABLE 2 — FAMILY/FRIEND

CLOSE CONTACT	N	M	SD	T	DF	P	95% CI LL	UL
Yes	52	16.06	5.84	−0.36	61	.72	−4.42	3.08
No	11	16.73	4.52					

Key Takeaway: Neither personal sexual trauma history nor close contact trauma history significantly predicted clinician willingness to treat child PSB, suggesting treatment readiness is shaped by professional factors rather than lived experience.

Results – PSB History and Willingness to Treat

NOT SIG. No significant difference in willingness scores for clinicians with a history of personal PSB t(61) = 0.70, p = .49

NOT SIG. No significant difference in willingness scores for clinicians with a close contact with PSB history t(61) = -1.04, p = .30

Table 1 — Personal PSB History

GROUP	N	M	SD	T	DF	P	95% CI LL	UL
Yes	7	17.57	5.71	0.70	61	.49	-2.94	6.08
No	56	16.00	5.62	—	—	—	—	—

p = .49 — difference not statistically significant

Table 2 — Family/Friend PSB History

GROUP	N	M	SD	T	DF	P	95% CI LL	UL
Yes	20	15.10	6.52	-1.04	61	.30	-4.61	1.46
No	43	16.67	5.13	—	—	—	—	—

p = .30 — difference not statistically significant

How do Findings Relate to the Literature?
Therapist Readiness & Emotional Regulation

Confirms Anderson's (1986) staged model: emotional readiness develops through exposure and reflection

Aligns with Harris & Hays (2008): therapeutic neutrality reflects emotional maturity and boundary clarity

Extends Bowen's Family Systems Theory: sexual comfort reflects applied differentiation, even if DoS was not statistically significant

LITERATURE CONNECTION

How do Findings Relate to the Literature?

Multidimensional Nature of Sexual Comfort

BUILDING ON FOUNDATIONAL RESEARCH

Builds on Graham & Smith (1984): sexual comfort includes **cognitive**, **emotional**, **behavioral**, and **interpersonal** dimensions

Cognitive | Emotional | Behavioral | Interpersonal

CURRENT STUDY IMPLICATIONS

Suggests sexual comfort is an **active stance** rooted in self-awareness, emotional regulation, and clinical presence

How do Findings Relate to the Literature? — Experiential Learning

Reinforces Hanzlik & Gaubatz (2012): clinician preparedness shaped by **exposure and supervision**

Supports Miller & Byers (2012): **sexual comfort and intervention self-efficacy** predict willingness to treat sexual issues

Highlights **experiential learning** as more impactful than personal trauma history

DISCUSSION

How do Findings Relate to the Literature?

Lived Experience & Countertransference

Challenges Assumptions About Lived Experience

Personal trauma history did not predict willingness to treat, challenging the common assumption that clinicians' own experiences of trauma would either facilitate or hinder their engageme
child PSB cases.

Diverges from Chaffin et al. (2009)

Countertransference may warrant renewed attention in child PSB contexts. The findings suggest that the dynamics between clinician history and clinical engagement are more nuanced thar
previously understood in the literature.

High Prevalence of Trauma History May Subtly Influence Decision-Making

The high prevalence of trauma history among clinicians in the sample suggests that these experiences may subtly influence clinical decision-making in ways not captured by direct measurem
warranting further investigation.

CONNECTING RESULTS TO THEORY

How do Findings Relate to the Conceptual/Theoretical Framework?

Examining results through the lens of Bowen's Family Systems Theory and Self-Efficacy frameworks

CONCEPTUAL & THEORETICAL FRAMEWORK

Bowen's Family Systems Theory

Emphasizes **emotional regulation**, **boundary clarity**, and **self-awareness** in complex relational systems

Sexual comfort reflects **applied differentiation**: clinicians remain grounded despite discomfort or stigma

DoS (Differentiation of Self) did not predict willingness to treat statistically, but conceptually aligns with traits observed in engaged clinicians

Self-Efficacy & Sexual Intervention Self-Efficacy

Builds on Miller & Byers (2012): clinicians confidence in addressing sexual issues predicts treatment willingness

Sexual comfort may function as a proxy for intervention self-efficacy in child PSB contexts

Reinforces need for experiential learning and supervision to cultivate both emotional readiness and technical skill

SECTION V

Limitations of the Study

Acknowledging boundaries to strengthen future research

Limitations of the Study

SAMPLE SIZE & STATISTICAL POWER

- N = 63 fell short of recommended 85; may affect model interpretation
- Skewed outcome variable (willingness to treat) challenges normality assumptions
- Low response rate excluded some demographic subgroups from analysis

SAMPLE ACHIEVED **63 / 85**

74% of recommended

MEASUREMENT & CONSTRUCT VALIDITY

- Overlap among sexuality-based predictors may obscure distinct effects
- Willingness to treat scale had only 4 items; possible ceiling effect and item redundancy
- No social desirability measures included — risk of response bias

4	0	PREDICTOR OVERLAP
SCALE ITEMS	DESIRABILITY CONTROLS	

Limitations of the Study (continued)

Recruitment & Representativeness

- 19-month recruitment yielded low engagement despite online format
- Sample predominantly female and Caucasian; limits demographic generalizability
- Extended timeframe may introduce temporal variability in responses

19 months of data collection with limited participation

Topic Sensitivity & Disclosure Bias

- Clinicians may overreport willingness due to professional norms or internal conflic
- Sensitive nature of child sexuality and PSB may inhibit honest participation
- Lack of engagement may reflect broader discomfort with PSB-related content

Social desirability bias may mask true willingness levels

Recommendations for Future Research

Measurement Refinement

- Develop comprehensive, validated scales for willingness to treat child PSB
- Use subscale analyses of DoS and SISE to uncover nuanced relationships
- Expand item count and specificity to improve construct validity

Sample Diversity & Size

- Recruit larger, more demographically diverse samples
- Explore differences across excluded response categories
- Enhance generalizability through broader geographic and professional representation

Recommendations for Future Research (continued)

Response Bias & Disclosure

- Incorporate social desirability scales and indirect questioning
- Address clinician discomfort and professional norms influencing self-report
- Strengthen validity by assessing subject matter avoidance

Training & Longitudinal Impact

- Investigate how supervision and experiential learning shape sexual comfort
- Conduct longitudinal studies to assess sustained changes in engagement
- Use qualitative methods to explore emotional and ethical dimensions

FUTURE RESEARCH

Behavioral Engagement as Outcome

SHIFT MEASUREMENT

Shift from attitudinal self-report to behavioral indicators of willingness

CLINICIAN CHARACTERISTICS

Examine clinician characteristics linked to actual treatment of child PSB

ECOLOGICAL VALIDITY

Use clinical engagement history as a more ecologically valid outcome

SOCIAL CHANGE IMPLICATIONS

Clinician Training & Development

Clinician Training & Development

- Embed sexual comfort preparation into graduate curricula
- Facilitate exposure to child PSB during internships and practicum
- Use experiential learning to reduce avoidance and increase readiness

PREPARATION · EXPOSURE · READINESS

Supervision Practices

- Equip supervisors to assess and address clinician discomfort
- Foster trauma-informed conversations around PSB cases
- Reinforce ethical boundaries and emotional regulation

GUIDANCE · SAFETY · REGULATION

SOCIAL CHANGE IMPLICATIONS

Agency & Systems

Agency-Level Strategies

- Promote early exposure to PSB cases through policy and practice
- Offer continuing education on child sexual development
- Support supervisors in cultivating clinician engagement

Systemic Impact

- Expand access to care for children with PSB
- Reduce treatment gaps and reliance on higher levels of care
- Strengthen family systems and enhance community safety

SOCIAL CHANGE IMPLICATIONS

Trauma-Informed Care & CSA Prevention

CLINICIAN EMOTIONAL SAFETY

Center clinician emotional safety in CSA prevention frameworks

HEALING-CENTERED SYSTEMS

Advance healing-centered systems responsive to sexual trauma

REIMAGINED CARE PATHWAYS

Reimagine care pathways that integrate emotional attunement with evidence-based practice

Conclusions

Foundational quantitative study investigating PSB treatment access barriers for children

Opens pathway for positive social change

Justification for future research:

- Child PSB rates and barriers to their access to care
- Prevalence of mental health clinicians not treating PSB during clinical interventions
- Factors that impact masters level clinicians willingness to treat child PSB

CONCLUSIONS

Key Takeaways

1

Clinician Preparedness Drives Change

- Sexual comfort and clinical exposure are key predictors of treatment willingness
- Emotional readiness enables clinicians to respond with competence, not avoidance

2

Children with PSB Are Present — But Underserved

- Nearly half of clinicians encountering PSB do not address it in treatmen
- Early intervention can reduce child-on-child sexual abuse and strengthe families

RESOURCES

Click the links below to access additional materials

1. **National Center for the Sexual Behavior of Youth**
   https://www.ncsby.org

2. **ATSA Report on Child Sexual Behavior Problems**
   https://depts.washington.edu/uwhatc/wp-content/uploads/2022/07/Report-of_ATSA.pdf

Thank You!

Questions & Discussion Welcome

EMERGE
CENTER FOR PEDIATRIC FAMILY DEVELOPMENT

www.EmergePediatrics.com
contact@EmergePediatrics.com
509-215-4030

References

Al-Darmaki. (2004). Counselor training, anxiety, and counseling self-efficacy: Implications for training psychology students from the United Arab Emirates University. *Social Behavior and Personality, 32*, 429-440.

Allen, B. (2017). Children with sexual behavior problems: Clinical characteristics and relationship to child maltreatment. *Child Psychiatry and Human Development, 48*(2), 189-199.

American Psychological Association. (2022). *Ethical Code of Psychologists and Code of Conduct.*

Anderson, W. (1986). Stages of therapist comfort with sexual concerns of clients. *Professional Psychology: Research and Practice, 17*(4), 352-356.

Bandura, A. (1997). *Self-efficacy: The exercise of control.* New York: Freeman and Company.

Bandura, A., Adams, N. E., & Beyer, J. (1977). Cognitive processes mediating behavioral change. *Journal of Personality and Social Psychology, 35*, 125-139.

Belluardo-Crosby, M. (2011). Mental illness and problematic sexual behaviors. *Journal of Psychosocial Nursing and Mental Health Services, 49*(2), 24-28.

Bloom, Z. D., Gutierrez, D., & Lambie, G. W. (2015). Sexual opinion survey. *American Journal of Sexuality Education, 10*(3), 242-260.

References

- Bowen, M. (1978). *Family therapy in clinical practice.* Jason Aronson.
- Chaffin, M., Berliner, L., Block, R., et al. (2008). Report of the ATSA task force on children with sexual behavior problems. *Child Maltreatment, 13*(2), 199–218.
- Chatterjee, S., & Hadi, A. S. (2012). *Regression analysis by example* (5th ed.). Wiley.
- Fall, K. A., Lasser, J., & Covington, J. (2022). Mental health providers responses to prospective client inquiries. *Professional Psychology: Research and Practice, 53*(3), 318–323.
- Faul, F., Erdfelder, E., Buchner, A., & Lang, A. G. (2009). Statistical power analyses using G*power 3.1. *Behavior Research Methods, 41*(4), 1149–1160.
- Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). Juveniles who commit sex offenses against minors. *OJJDP Juvenile Justice Bulletin.*
- Forester, M., Kahn, J. H., & Hesson-McInnis, M. S. (2004). Factor structure of three measures of research self-efficacy. *Journal of Career Assessment, 12,* 3–16.
- Fowler, F. J. (2014). *Survey research methods* (5th ed.). Sage.
- Friedrich, W. N., et al. (1998). Normative sexual behavior in children. *Pediatrics, 101*(4), e9.

References

- Friedrich, W. N., Grambsch, P., et al. (1992). Child sexual behavior inventory. *Psychological Assessment, 4*(3), 303-311.
- Graham, C. A., & Smith, M. M. (1984). Operationalizing the concept of sexuality comfort. *Journal of School Health, 54*, 439-442.
- Hanzlik, M. P., & Gaubatz, M. (2012). Clinical PsyD trainees comfort discussing sexual issues. *American Journal of Sexuality Education, 7*(3), 219-236.
- Harris, S. M., & Hays, K. W. (2008). Family therapist comfort with and willingness to discuss client sexuality. *Journal of Marital and Family Therapy, 34*(2), 239-250.
- Harvey, V., & McMurray, N. (1994). Self-efficacy: A means of identifying problems in nursing education. *International Journal of Nursing, 31*, 471-485.
- Heiden-Rootes, K. M., et al. (2017). Differentiation of self and clinicians perceptions of client sexual behavior as problematic. *Contemporary Family Therapy, 39*(3), 207-219.

References

- Heppner, M. J., et al. (1996). Training counselling psychologists in career development. *The Counselling Psychologist, 24*, 105–125.
- Holden, G., et al. (2002). Outcomes of social work education. *Journal of Social Work Education, 38*, 115–133.
- Jankowski, P. J., & Hooper, L. M. (2012). Differentiation of self: A validation study. *Couple and Family Psychology: Research and Practice, 1*, 226–243.
- Jenkins, C. S., et al. (2020). Preliminary findings of PSB-CBT for adolescents. *Child Abuse & Neglect, 104*, 4–28.
- Kenny, M. C., & Wurtele, S. K. (2023). Child sexual abuse prevention. *Journal of Child Sexual Abuse, 32*(2), 145–162.
- Kerr, M., & Bowen, M. (1988). *Family evaluation: An approach based on Bowen Theory.*
- Krienert, J. L., & Walsh, J. A. (2011). Sibling sexual abuse. *Journal of Child Sexual Abuse, 20*(4), 353–372.

References

- **Malvaso, C. G., et al.** (2019). *Characteristics of children with problem sexual behavior.* Journal of Sexual Aggression.
- **McGrath, R. E.** (2011). *Practical issues in null hypothesis significance testing.* Quantitative Models in Psychology, 73-90.
- **McKibbin, G.** (2017). *Preventing harmful sexual behavior and child sexual exploitation.* Children and Youth Services Review, 82, 373-382.
- **McKibbin, G., & Humphreys, C.** (2020). *Future directions in child sexual abuse prevention.* Child Abuse and Neglect, 105, 104422.
- **Miller, S. A., & Byers, E. S.** (2008). *Sexual intervention self-efficacy of clinical psychology graduate students.* Training and Education in Professional Psychology, 2, 137-144.
- **Miller, S. A., & Byers, E. S.** (2010). *Psychologists sexual education and training in graduate school.* Canadian Journal of Behavioral Science, 42(2), 93-100.
- **Miller, S. A., & Byers, E. S.** (2012). *Practicing psychologists sexual intervention self-efficacy.* Archives of Sexual Behavior, 41(4), 1041-1050.

References

Mundey, P., et al. (2020). Qualitative analysis of administrator, provider, and stakeholder views. *Administration and Policy in Mental Health, 47*, 126–137.

Nevill, D. D., & Schlecker, D. I. (1988). The relation of self-efficacy and assertiveness. *Psychology of Women Quarterly, 12*, 91–98.

Norton, L. R. W., et al. (1986). Self-efficacy in the prediction of academic performance. *Journal of Counseling Psychology, 33*, 265–269.

Pryzgoda, J., & Chrisler, J. C. (2000). Definitions of gender and sex. *Sex Roles, 43*(7-8), 553–569.

Radford, L., et al. (2011). Child abuse and neglect in the UK today. NSPCC.

Shields, R. T., et al. (2020). Help wanted: Lessons on prevention from young adults. *Child Abuse & Neglect, 105*.

Shields, J. D., et al. (2020). A qualitative examination of factors impacting family engagement. *Children and Youth Services Review, 108*.

References

- Shields, J. D., et al. (2018). A qualitative analysis of family perspective on treatment services. *Victims & Offenders, 13*(7), 955–973.
- Shlonsky, A., et al. (2017). Rapid evidence assessment: Therapeutic treatment of children with problem sexual behaviors. *Royal Commission into Institutional Responses to Child Sexual Abuse.*
- Short, M. B., et al. (2016). Clinicians beliefs regarding clients sexual addiction. *Community Mental Health Journal, 52*(8), 1070–1081.
- Silovsky, J. F., & Bonner, B. L. (2003). Sexual behavior problems. *Encyclopedia of Clinical Child and Pediatric Psychology,* 589–591.
- Sites, J., & Widdifield, J. Jr. (2020). Children with problematic sexual behavior: Recommendations. *National Childrens Alliance.*
- Skowron, E. A., et al. (2003). Deconstructing differentiation. *Contemporary Family Therapy, 25,* 111–129.
- Skowron, E. A., & Friedlander, M. L. (1998). The Differentiation of Self Inventory. *Journal of Counseling Psychology, 45*(3), 235–246.

References

- Skowron, E. A., & Schmitt, T. A. (2003). Assessing interpersonal fusion. *Journal of Marital and Family Therapy, 29,* 209–222.
- Slemaker, A., et al. (2021). Barriers to accessing treatment services. *International Journal of Environmental Research and Public Health, 18*(10), 5302.
- Sloan, D., & Dierendonck, D. V. (2016). Item selection and validation of a brief DSI-Revised. *Journal of Personality and Individual Differences, 97,* 146–150.
- Soodak, L. C., & Podell, D. M. (1994). Teachers thinking about difficult to teach students. *Journal of Educational Research, 88,* 44–52.
- SurveyMonkey. (2023). How long should a survey be open?
- SurveyMonkey. (2021). Audience: Get results in minutes.

References

1. **Taylor, E. K., Slemaker, A., & Silovsky, J. F.** (2020). *Professionals perceptions of electronic and online sexual behaviors of youth.* Children and Youth Services Review, 111.

2. **Tener, D., et al.** (2019). *Child advocacy center intervention with sibling sexual abuse cases.* Child Abuse & Neglect.

3. **United States Bureau of Labor Statistics.** (2022). *Occupational Outlook Handbook.*

4. **Wamser-Nanney, R., & Campbell, C.L.** (2019). *Childhood sexual abuse characteristics.* Child Abuse and Neglect, 105, 104290.

5. **Wurtele, S. K., & Kenny, M. C.** (2022). *Child sexual abuse prevention: A critical review.* Child Abuse Review, 31(1), 5–20.