The Assessment of Sexual Behavior-Child Version (ASB-C)

A Manual for Administration, Scoring, and Interpretation

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CHAPTER 1:
Introduction

Sexual development is an important part of human development. Sexual behavior may be observed throughout childhood, but is commonly misunderstood and is influenced by cultural mores, societal rules and expectations, social conditions, contextual cues, and individual factors (e.g., developmental level, age, gender). In many cultures, the topic of childhood sexual behavior is taboo, uncomfortable, and leads to avoidance. As such, sexual development in childhood historically has been difficult to discuss, measure, and research, which consequently has hindered professionals' ability to better understand and guide healthy sexual development and behavior in childhood.

Measurement of sexual behavior is a critical component to understanding and addressing sexual development. The *Assessment of Sexual Behavior – Child Version (ASB-C)* is designed to measure sexual behavior in children ages 3-12. Normative sexual behavior begins in infancy and a measure of sexual behavior in childhood must include behaviors commonly observed in the course of normal growth and development. Sexual behavior also falls on a continuum in which behaviors can be conceptualized as normative, cautionary, problematic, or even harmful. Multiple factors including situational context, frequency, duration, responsivity to adults' supervision and attempts to correct the behavior, and use of coercion impact decision-making on where a sexual behavior falls on the continuum and the appropriate responses to a given behavior. The ASB-C was developed to identify a range of sexual behaviors and measure the frequency and commonality of these behaviors to facilitate decision-making. A standardized psychometrically sound measure of sexual behavior that includes more modern forms of

behaviors, such as electronic and online sexual behaviors, is essential for researching sexual development in children and is an important component of clinical evaluations of sexual behavior. The ASB-C is designed to fill these needs.

This introduction provides background information and a summary of factors to consider when using the ASB-C for clinical or research purposes. This includes the normative developmental progression of sexual behavior, cultural and societal influences, a contemporary definition of problematic sexual behavior (PSB), etiological and contextual factors believed to underlie PSB, and other important aspects to consider when evaluating PSB and using the ASB-C. Finally, this chapter ends by describing the existing shortcomings of assessing childhood sexual behavior that the ASB-C is designed to address. After this introduction, the remainder of this manual is devoted to describing the development of the ASB-C, administration and scoring, interpretation and application of the ASB-C, and the psychometric background of the measure, including factor structure, reliability, validity and standardization. Note that the background information provided is a brief overview, and not the comprehensive background essential for clinicians utilizing the ASB-C for clinical purposes.

Background Information on Sexual Development and Sexual Behavior

Sexual development and behavior are complex and multifaceted constructs influenced by various aspects of socioemotional, physical, cognitive, language, social, moral, and familial development, as well as family values, beliefs, and other cultural factors. Although many caregivers and professionals focus on puberty as the start of sexual development, knowledge and behaviors regarding sexual topics and body parts begin in infancy (Cacciatore et al., 2019). From a physical perspective, children learn at an early age that genital stimulation results in unique sensations. Later, the physical changes that occur with puberty are often accompanied by a

greater awareness and interest in a range of topics and activities related to sexuality and sexual behavior. Puberty has been starting at earlier ages over the last several decades, now commonly occurring between 8 and 14 years of age in many Western countries (Campbell, 2011; Herdt & McClintock, 2000). From a cognitive perspective, preschoolers evolve in terms of their understanding of gender and biological sex differences, including how children's and adult's bodies and behaviors are distinct (Brilleslijper-Kater & Baartman, 2000; Cacciatore et al., 2024). Related concepts of boundaries, body autonomy, consent, and social rules of interactions evolve throughout early and middle childhood (Silovsky, 2009). Understanding reproduction and sexual attraction is initially basic and concrete and progresses with cognitive development as their ability to understand complex and abstract concepts grows. Quality of understanding depends on being taught accurate information and is impacted as exposure to various influences increases and broadens (e.g., family, peers, school, community, internet/online community). Considering social development, children typically learn that social contexts dictate different rules about appropriateness of behavior (e.g., people may walk around their homes partially dressed or nude, but such behavior is not permitted at school). Similarly, children learn social cues from caregivers, siblings, peers, teachers, social media, and others about permissible behavior and topics of conversation as well as those that are taboo and may result in negative consequences if discussed. In short, sexual development is as much a part of growing up as is any other form of physical or psychological concept, and is therefore amenable to psychological assessment and scientific investigation.

As with other forms of development, the topic of sexual development must be considered within the broader cultural context. One popular way of examining cultural differences of sexual development is to examine normative behavior from an international perspective. For example,

when looking at the behavior of touching one's own "private parts" at home, Friedrich et al. (2000) found that approximately 91.6% of female and 94.7% of male Dutch children between the ages of 2 and 6 years displayed this behavior in the prior six months. In contrast, endorsement rates with similar aged samples were 43.8% (female) and 60.2% (male) in the United States (Friedrich et al., 1998) and 14.7% (female) and 25.2% (male) in South Korea (Choi & Song, 2022). An alternative perspective examines ethnic and racial differences within a single country. Also examining preschoolers and the behavior of touching one's own "private parts" at home, Kenny and Wurtele (2013) found that Latina mothers in the United States reported that 37.6% of girls and 40.2% of boys displayed this behavior, suggesting a significantly lower frequency than that documented in Friedrich et al.'s (1998) general sample of American children. Similarly, Thigpen (2009) observed that only 21.7% of preschoolers displayed this behavior in an African American sample described as religious and conservative.

In reality, culture encompasses innumerable and intersecting aspects of life, including the ethnic and racial factors, gender roles and typing, self-identification, socioeconomic status, religious beliefs and practices, political views, and urbanicity vs rurality, to name a few (see Hayes, 2007, for a review). The impact of cultural influences on sexual development cannot be understated: they may socialize the child to act in specific ways, convey messages regarding the acceptability of different types of behavior, influence the material taught in schools, and create biases in how caregivers report on their child's behavior, among other effects (see Frayser, 2003). Lastly, it is important to remember that cultures evolve over time and what is accepted and promoted in one era may bear little resemblance to the cultural perspective prevailing during a different era. This necessitates a clinician maintaining awareness of current cultural

conceptualizations of sexual behavior and researchers continuing to document and study changes in these conceptualizations.

Context matters. Sexual behaviors found to be normative in one setting can be considered inappropriate or problematic in another (e.g., in the bedroom vs. in the classroom) and if it occurs too frequently. Further, understanding of how cultural context defines normative behavior facilitates identification of behavior that goes beyond acceptable limits. However, in all known cultures, coercive and harmful forms of behaviors are considered problematic even if they occur only once.

Definition and Types of Problematic Sexual Behavior of Children.

The most common definition of problematic sexual behavior (PSB) among preteen children (ages 3-12 years) is "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; p. 200). Made clear in this definition is that PSB may present in multiple forms, including but not limited to: *self-focused behaviors* (e.g., inserting objects into oneself, self-stimulating to the point of injury), *interpersonally intrusive behaviors* (e.g., touching the private parts of others, coercing others to perform sexual behaviors), *looking behaviors* (e.g., trying to look at people in the shower or bathroom), and *showing behaviors* (e.g., intentionally exposing one's private parts to others). In addition, *intrusive thoughts or excessive interest* in sex may result in significant problems for the child and family (e.g., discussing sexual acts with peers at school, playing with toys in a sexualized manner). Given 21st century technological innovations, there are presently significant concerns regarding children's *electronic/online sexual behaviors* (EOSB) as well, such as viewing online pornography or sending/receiving sexually explicit pictures or messages (i.e., "sexting"). Given these diverse

forms of presentation, it is important to emphasize that PSB is not a singular diagnosis; rather, it is a concerning behavior that may be a focus of clinical attention and it frequently co-occurs with a variety of disorders, such as disruptive behavior disorders, posttraumatic stress disorder, internalizing concerns (e.g., depression, anxiety), and learning and developmental concerns.

It is not possible to list every type of specific behavior that may fall under the broad rubric of PSB. However, accurately understanding normative behavior and its context facilitates determining whether a given behavior is problematic. In a series of studies throughout the 1990s, Friedrich demonstrated that the frequency of different behaviors varied based on the age of the child assessed. For instance, undressing in front of others was relatively frequent at younger ages, implying developmental normality (49.6-61.9% of 2-6-year-olds), but less common among older ages (fewer than 23% of 7-12-year-olds; Friedrich et al., 1991; Friedrich et al., 1992). , Further, touching a female's breast is a fairly common occurrence for preschool-aged children, likely reflecting a curiosity about different body parts and a relatively poor understanding of personal boundaries, both of which are developmentally expected for a child of this age. Yet, this behavior continuing despite correction and/or the child being so preoccupied with touching breasts that it interferes with normal daily functions (e.g., play, relationships) is outside of developmental expectations and may be problematic. A 12-year-old intentionally touching a woman's breast typically is considered outside of developmental norms based on chronological age and may be considered problematic regardless of frequency. This example highlights that any measure of childhood sexual behavior must, by necessity, include behaviors that are considered normative at different developmental periods as well as those that are easily identified as problematic. Also, this discussion underlines the importance of conducting an

effective assessment to determine whether a given behavior is within normative expectations or is problematic, which is discussed below.

Problematic Sexual Behavior: Prevalence, Etiology, and Co-Occurring Factors

Obtaining accurate estimates of the prevalence of PSB is complicated as large-scale longitudinal research has yet to be conducted, and the measurement issues leading to the development of the ASB-C were problematic. Research with specific populations (e.g., preschoolers) indicates the PSB is not rare. Lussier et al. (2018) provided data examining the prevalence of interpersonally intrusive behavior among preschoolers. In a socioeconomically diverse sample of Canadian children ages 3 to 5 years, 17% engaged in at least one such behavior in the prior 12 months. However, it is unclear the percentage of these children whose behaviors were of sufficient frequency and/or severity to qualify as PSB, and the researchers included attempts to look at people nude or undressing, which if fairly common for this age, within their definition of intrusive behavior. When these children were re-assessed approximately three years later, nearly 12% had displayed interpersonally intrusive behavior in the preceding 12 months. Allen (2017), using a 26-item measure and the data collected by Friedrich et al. (2001) to define developmental norms, found that 22% of 8-year-old children drawn from predominantly low socioeconomic and/or maltreated samples displayed a sufficient frequency and/or diversity of sexual behaviors within the prior six months to qualify as exhibiting PSB (i.e., elevated T-scores on a measure of sexual behavior). As such, although the prevalence of PSB is unknown, it does appear to present within a significant minority of children.

Studies examining the persistence of PSB underscore the need for appropriate clinical assessment and intervention. Ensink et al. (2018) followed children referred for a sexual abuse

evaluation and found that 56.7% of children displaying PSB (i.e., elevated T-score) at the initial assessment continued to display PSB two years later. Perhaps more concerning, Lévesque et al. (2012) restricted their sample to 49 children referred to child protective services and displaying any interpersonally intrusive PSB, and found that 43% continued to show these behaviors one year later. In the longitudinal study by Lussier et al. (2018), they discerned four trajectories of PSB from the preschool age to middle childhood. Two of these trajectories demonstrated low rates of PSB both initially and during follow-up assessments. However, a third group exhibited a moderate number of PSB behaviors that was stable over time (48% of sample) and often included children displaying interpersonally intrusive PSB. The final group was composed of children who demonstrated the highest frequency of PSB behavior (13% of sample), which increased in frequency over the years, and nearly all of these children engaged in interpersonally intrusive PSB.

The lessons from these studies are numerous. First, there is significant variation in the types of behaviors considered to be normative, and therefore those considered problematic, depending on the developmental level of the child being assessed and the context of the behavior. Second, in the absence of normative data within a given culture and time, it is often difficult to accurately describe the types of behavior that might qualify as “developmentally inappropriate.” Third, it is important to identify the phenomenology of the sexual behavior under examination, with the most commonly employed definitions being either a broad conceptualization encompassing various forms of behavior, or the more specific presentation of interpersonally intrusive behaviors (i.e., touching another individual). Lastly, PSB may be more common and persistent than many realize; although it is difficult to ascertain these numbers in

the absence of a valid and reliable measure that accounts for contemporary cultural and social contexts.

Etiological and concurrent factors related to PSB development inform clinical assessment and decision-making. Although originally conceived as an outcome likely stemming from the experience of childhood sexual abuse (CSA) and potentially the result of posttraumatic stress disorder (PTSD; Finkelhor & Browne, 1985), our contemporary understanding of PSB tempers this earlier hypothesis. Although children exposed to CSA are at significantly increased risk for the development of PSB (Friedrich et al., 2001), many children presenting with PSB do not have a history of CSA (Allen, 2017; Bonner et al., 1999; Silovsky et al., 2007; Silovsky & Niec, 2002). There are also mixed results regarding the role of PTSD symptoms. Some studies employing bivariate correlations between PTSD symptoms and generalized PSB find a significant relationship, particularly among children with a history of CSA (e.g., Allen et al., 2015; Simmons et al., in press; Wamser-Nanney & Campbell, 2020). However, this relationship commonly fails to emerge when specifically examining interpersonally intrusive PSB (e.g., Wamser-Nanney & Campbell, 2020; Friedrich et al., 2003) or when co-occurring experiences and concerns, such as physical abuse and general behavior problems, are controlled (e.g., Allen, 2023a; Wamser-Nanney & Campbell, 2022). In short, the display of PSB does not necessarily imply a history of sexual abuse or the presence of posttraumatic stress disorder. Rather, there are a range of vulnerability and protective factors to consider when evaluating sexual behavior of youth.

More current etiological perspectives emphasize the broader developmental progression of children as opposed to an exclusive focus on CSA. Several studies demonstrate that various untoward experiences increase the risk for PSB, including childhood sexual and/or physical

abuse, exposure to intimate partner violence, parental stress and mental illness, and physical discipline (Allen, 2017; Cale & Lussier, 2017; Latzman & Latzman, 2015; Lévesque et al., 2010; Merrick et al., 2008; Silovsky & Niec, 2002; Tremblay et al., 2020; Wamser-Nanney & Campbell, 2019; Wamser-Nanney et al., 2019). This understanding typically emphasizes that developmental adversities place the child at risk for problems with regulating emotions and behaviors (e.g., ineffective coping skills, impulsivity), which create the more immediate risk for displaying PSB (Allen, 2023b; Elkovitch et al., 2009). Indeed, several studies demonstrate high co-occurrence of PSB with impulsivity, aggression, and other externalizing problems (Allen et al., 2025; Bonner et al., 1999; Friedrich et al., 2003; Lévesque et al., 2010; Smith et al., 2019; Tremblay et al., 2020; Wamser-Nanny & Campbell, 2019). Neurodiversity is another important consideration in understanding the context of sexual behavior and risk for PSB. The social, emotional, and cognitive development of children with autism and other neurodiversities impacts sexual development and social interactions in multiple ways including interpretation of nonverbal cues, understanding of boundaries and consent, caregiver's approach to sex education, as well as risk for sexual abuse (e.g., Mandel & Datner, 2017).

It is also important to not overlook the impact of social modeling on the development of PSB. In some of the earliest work on PSB, Friedrich repeatedly observed that more frequent displays of sexual behavior in the home increased the risk of PSB (e.g., co-bathing, nudity, presence of pornography; Friedrich et al., 1992; 2003). Several studies since that time similarly show that exposure to sexual modeling increases the risk for PSB and may be a critical factor that distinguishes children who display PSB from those who exhibit non-sexual forms of behavior problems (Bonner et al., 1999; Cale & Lussier, 2017; Lévesque et al., 2010). A recent meta-analysis summarized this relationship by finding that exposure to sexual modeling doubled

the risk of a child displaying PSB (Mori et al., 2023). This type of modeling may occur in several forms, including sexual behaviors occurring in front of the child, exposure to pornography or other forms of sexualized media, or through the direct experience of CSA. As such, social modeling of sexual behavior may occur during situations in the home, through discussions or experiences with peers, by viewing sexually explicit media, and/or as a result of encounters in the community.

Clinical Assessment of PSB

As described above, a multitude of factors may be operative in cases of PSB, including emotional and behavioral dysregulation, posttraumatic stress, social modeling, contextual and familial factors, and a history of adverse and traumatic events. An appropriate clinical assessment must attend to these diverse influences. Assessment of PSB should include a good clinical interview with a caregiver that establishes the details of the behavior as well as its frequency, severity, and onset. In addition, an appropriate trauma and adversity screen is needed to document prior experiences that may be relevant to the display of PSB. It is important that the clinician not prematurely focus on the PSB and fail to identify other potential co-occurring emotional and behavioral problems as PSB frequently is only one aspect of a broader picture of clinical concerns. It is recommended that any assessment of PSB include a broadband measure of childhood psychopathology (e.g., the Child Behavior Checklist [CBCL], the Behavior Assessment System for Children [BASC], the Strengths and Difficulties Questionnaire [SDQ]) and a specific measure of posttraumatic stress (e.g., the Child and Adolescent Trauma Screen [CATS], the Trauma Symptom Checklist for Young Children [TSCYC]). For an in-depth discussion of the multiple layers and processes recommended for assessing PSB, reference the

report from the Association for the Treatment and Prevention of Sexual Abusers (ATSA) Task Force on Children with Sexual Behavior Problems (2023).

In addition, any attempt to assess PSB must utilize a valid and reliable measure of sexual behavior among children. Implementing such a measure offers several benefits, including thoroughly assessing the diversity of sexual behaviors that may occur, providing an efficient means of assessing those behaviors, and allowing for a comparison of an individual report to normative data to prevent over-pathologizing. Ideally, such a measure also will be sensitive to change to allow for monitoring of treatment progress.

The Need for a New Measure of Sexual Behavior and PSB

Given that sexual behavior is an important aspect of development and a topic for clinical assessment, a psychometrically-validated measure is required to guide understanding and practice. Such a measure must address a range of sexual behaviors, including those that are typical, concerning, problematic, and harmful, and it must be appropriately anchored within our contemporary cultural and social climate. This necessitates that the measure effectively assesses the prevailing concerns related to EOSB. From a clinical perspective, a measure of PSB must facilitate clinical decision-making and safety planning, such as who was involved in a given behavior and whether coercion was used. From a scientific perspective, an adequate measure of sexual behavior should enhance our ability to research various aspects of child well-being, the development of sexual behavior, cross-cultural differences, and etiological factors in the emergence of PSB.

Currently available measures of childhood sexual behavior, including PSB, are limited in several ways. First, they were developed decades ago and, in most cases, the normative data used to determine when behaviors should be considered normative or problematic are several decades

old. Our society and culture have evolved significantly during this time and it is advisable to not use these outmoded data for contemporary purposes. Second, many of the most well-known measures of sexual behavior were designed with a specific focus on assessing PSB secondary to sexual abuse (e.g., the Child Sexual Behavior Inventory [CSBI; Friedrich, 1997], the Sexual Concerns subscale of the TSCYC [Briere, 2005]). As a result, these measures display an inordinate number of items designed to assess sexually-based displays of anxiety and posttraumatic stress. Third, none of the measures currently promoted for the clinical assessment of PSB include items asking about the display of EOSB, and many of these measures were developed prior to the advent of the internet and other contemporary technological innovations. Fourth, the available measures are proprietary and often require a significant investment of financial resources to utilize them consistently. The implementation of valid and reliable measures for assessment and outcome monitoring is a primary focus for those disseminating evidence-based practices, and the lack of affordable and accessible measures has proved a significant barrier (Cho et al., 2021).

A clinically useful measure of sexual behavior, as a part of an assessment of PSB, must adhere to several standards. First, it must adequately assess each of the diverse forms of sexual behavior (e.g., self-focused, interpersonally intrusive), including EOSB. Second, it must recognize that children undergo a normative process of sexual development and not pathologize normative behavior. In other words, it must be norm-referenced. Third, it must be flexible enough to identify developmentally anomalous behaviors, whether that be the result of inappropriate knowledge/awareness for a given age or because of excessive frequency, across the diverse periods of childhood (i.e., preschool, school-age, pre-teen). And, fourth, it must be applicable to research and clinical practice across a wide range of settings and not be geared

toward the assessment of children experiencing sexual abuse or any other hypothesized etiological factor.

Towards this end, a team of experts met in 2015 to begin the process of specifying a new measure of childhood sexual behavior and PSB. The team chose to start by surveying practicing clinicians to ascertain their needs and desires for such a tool and kept a constant eye on clinical utility throughout the development process. The **Assessment of Sexual Behavior-Child Version** (**ASB-C**) took shape over several years of writing, testing, obtaining feedback, and revision; a process that was repeatedly interrupted by competing academic and clinical demands, funding shortfalls, and the COVID-19 pandemic. Details on the developmental process of the ASB-C can be found in Chapter 2. All team members have agreed to make the ASB-C freely available for clinical and research purposes. We ask that references to the ASB-C in professional publications or presentations use the citation provided below. In addition, we request that any modifications made to the ASB-C be clearly specified within the context of publications and presentations to identify how its usage deviated from the instructions provided within this manual.

It is important to note that this measure is designed to be an important tool for clinical assessment of sexual behavior of children, and in cases of concerning and problematic sexual behavior of youth, clinical assessments require the examination of abuse and trauma history, co-occurring emotional, behavioral, and developmental concerns, and vulnerability and protective factors at the individual, caregiver, family, school, community, and society levels. Further, PSB may result in significant functional consequences for the child engaging in the behaviors, such as emotional effects (e.g., shame, guilt), physical injuries, family separations, and school suspensions, among other outcomes. When older youth have interpersonally intrusive behaviors that violate the autonomy and rights of another individual it is also considered to be illegal.

Depending on the jurisdiction where the behavior occurred, children within this age range (e.g., 10 – 12-year-olds) may be adjudicated and charged with a sexual offense. When providing clinical assessment and care of Children with PSB, level of legal involvement, state and federal statutes, timing (pre- or post-adjudication), and purpose may impact forensic and clinical assessment.

Interpersonal sexual behavior of children may have real and important consequences to other children involved, such as siblings, and these other children will likely require screening/assessment to determine need for interventions. Further, clinical assessment of PSB in children inevitably involves safety planning in the home and community. Given the impacted children, siblings, and the frequency of abuse and trauma in children with PSB, child protective and child welfare services may be involved in addressing the safety and well-being of all children involved. Other professionals and agencies may be involved in the case such as child advocacy, law enforcement, health care, schools, and juvenile justice. Clinical assessment and decision making should not be done in isolation. Rather, best practices are collaborative and interdisciplinary.

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Disclaimer:

The results of this measure do not constitute medical or psychological advice. Clinicians must conduct an appropriate evaluation and use best judgment in making clinical decisions.

CHAPTER 2:
Development of the ASB-C

From the beginning, the development team had three objectives: craft a measure that adequately addressed current trends in the field (e.g., internet usage, coercive behavior), develop a measure that was based on the extant empirical knowledge regarding the etiology and clinical care of children with PSB, and make the measure easily accessible to practicing clinicians. With this last goal in mind, one of the first decisions of the development team was to commence a survey of mental health clinicians to determine what they most needed from a new measure of childhood sexual behavior, including the assessment of PSB.

Clinician Input

The developed survey was forwarded to various professional listservs (e.g., the American Professional Society on the Abuse of Children [APSAC]), clinicians who previously attended trainings related to PSB, and known colleagues who specialized in treating youth with PSB, among other avenues. A total of 330 professionals responded over the course of six months. When asked an open-ended question about the characteristics they would most like to see in a new measure, the most common responses were:

(1) Ease of use

(2) Assessing age-appropriate and age-inappropriate behaviors

(3) Brief duration/time to administer

(4) Availability of a caregiver-report and child self-report version

(5) Assessing the frequency of behaviors

Clinicians were then presented with several potential characteristics of an assessment measure and asked to rank how important each factor was on a scale from 1 (*Not Important*) to 5 (*Very Important*). The five highest scoring items were:

(1) Scoring helps determine if a behavior is problematic ($M = 4.55$)

(2) Scoring helps guide which behaviors need to be targeted in treatment ($M = 4.55$)

(3) Ease of interpretation ($M = 4.54$)

(4) Inclusion of "critical items" ($M = 4.51$)

(5) Scoring includes a comparison to normative scores ($M = 4.50$)

Of the responding clinicians, approximately 25% ($n = 84$) stated that they do not currently administer a measure of childhood sexual behavior as part of their clinical practice. When asked to specify a reason, the overwhelming majority stated there are no accessible instruments due to either financial cost or the time required to administer, score, and interpret.

Finally, the clinicians were asked how likely they would be to administer a measure of PSB during the intake assessment under different conditions. Using a scale ranging from 1 (*Not at all likely*) to 5 (*Very likely*), the most preferred option was "A screener with 5-10 questions" ($M = 4.4$) with the least preferred option being "A full-length measure with more than 20 questions" ($M = 3.2$). Alternatively, clinicians were asked how much time they would be willing to devote during the intake assessment to the administration of a measure assessing sexual behavior and PSB. While 91.5% indicated a willingness if it took no more than 5 minutes and 72% indicated a willingness if the assessment was completed within 10 minutes; only 32.6% were willing to devote more than 10 minutes.

From this input, the team gleaned the following lessons. First, the measure must be simple to administer, score, and interpret. Second, the tool must have obvious clinical relevance

to clinicians, particularly by highlighting those behaviors most outside developmental expectations and/or considered problematic by current definitions. Third, the instrument must be cost-affordable and easily accessible. Finally, clinicians are willing to administer a measure of sexual behavior and PSB, but not if the time and/or length of the tool is deemed excessive. This last point left the team searching for a solution, as any measure of sexual behavior that adequately assesses the diversity of behaviors described in Chapter 1 is likely to be 30 to 40 items in length and, perhaps, considered too lengthy by some clinicians. The team decided to develop a screener of no more than 10 items alongside the full measure. However, the developed screener did not perform well during psychometric evaluation and is not discussed further. Clinicians interested in a screening tool are referred to Allen and Ferrer Pistone (2023).

Development of the Initial Pool of Items

After completion and compilation of the clinician feedback, the development team met to construct an initial pool of items. The team's goal was to develop a large number of items assessing each of the following areas: (a) self-focused behaviors, (b) looking behaviors, (c) showing behaviors, (d) interpersonal/coercive/intrusive behaviors, (e) sexual talking behaviors, and (f) sexual interest-related behaviors. EOSB items were developed within each of these areas alongside "in-person" forms of behaviors. For instance, "sends sexual messages digitally" was included within the *sexual talking behaviors* category while "takes pictures of nude or partially dressed people" was included within the *sexual looking behaviors* category. The initial pool included 79 items.

Two pilot studies tested the acceptability of the initial pool of items to caregivers. First, the items were presented to a focus group of caregivers whose children previously presented with PSB and who participated in treatment alongside their children. The caregivers discussed the

items and provided a number of recommendations to the team, many of them involving wording changes they thought better clarified the content. For instance, they recommended using the phrase “private parts” in place of “sexual body parts” or “genitals,” and preferred the term “digital” over “electronic.” The group also identified instances where the wording of items was either unclear or could be interpreted in different ways. In addition, the group provided suggestions for additional items. Overall, the caregivers expressed satisfaction with the measure and comfort responding to the items.

Second, a small sample of caregivers (n = 18) recruited from pediatric primary care clinics (i.e., children with no known PSB) were asked to complete a web-based survey in exchange for a $10 gift card. After reading through and responding to the items, caregivers were asked a series of questions. All caregivers described the instructions and the items themselves as either “easy” or “very easy” to understand. In keeping with the focus group discussed above, the survey participants overwhelmingly preferred the term “private parts” (92%) over “sexual parts,” and the term “digital media” (92%) over the term “electronic media.” The majority of respondents (67%) reported feeling “comfortable” or “very comfortable” answering the items and only one respondent reported feeling “uncomfortable.” The same proportions of participants reported (a) being willing to complete the questionnaire a second time and (b) being comfortable with their child’s doctor seeing how they responded to the questionnaire.

Following this feedback from caregivers, the team worked to revise the items, keeping in mind both the comments received and the desire to maintain a measure that caregivers felt comfortable completing. Several items were re-worded, some items were combined or deleted, and new items were written. Following this process, the measure contained a total of 80 items.

Preliminary Psychometric Evaluation

The 80-item version of the experimental measure was administered to a sample of 470 caregivers drawn from normative (n = 370) and psychiatric (n = 100) samples. Participants were asked to complete the new measure, along with several other measures assessing various emotional and behavioral concerns, in exchange for a $10 gift card. The samples were recruited from an academic medical center serving an ethnically and socioeconomically diverse population. The normative sample included caregivers with a child between the ages of 3 and 12 years who had presented for a well-child visit within the past 12 months. The psychiatric sample included caregivers with a child between the ages of 3 and 12 years who was diagnosed with a disruptive behavior disorder (e.g., ADHD, Oppositional Defiant Disorder [ODD]) and who attended a mental health appointment (e.g., psychiatric consult, outpatient therapy) within the past 12 months. All caregivers were mailed an invitation letter that included a QR code and a weblink to the survey. A small sample of caregivers attending treatment for a child with PSB were asked to participate to identify any items that might be exclusively endorsed by this group (n = 5). These caregivers were given a recruitment flyer with a QR code and weblink when attending a treatment session.

Following data collection, a series of statistical analyses were computed, including (a) frequency counts of the endorsement of each individual item, (b) principal components analyses to identify potential scales, (c) between groups analyses comparing two subsamples (i.e., normative vs. psychiatric), and (d) correlations examining the relationship of the individual items and derived factors with the other emotional and behavioral concerns examined. The development team met multiple times to discuss these results and consider their implications. Through this process, the team combined expert opinion, clinical experience, and the obtained

statistical data to trim the measure to a 38-item version suitable for psychometric standardization. Items were deleted based on low rate of endorsement within the samples, repetitiveness with other items, and perceived lack of clinical utility. In addition, the team attempted to balance the desire to construct a comprehensive and useful measure with the goal of maintaining a manageable length that clinicians felt comfortable implementing in practice.

Standardization and Validation

Standardization and validation of the ASB-C included collecting data from three samples: a nationally representative sample of caregivers (n = 1,400), a racially and economically diverse sample of caregivers presenting to a medical clinic for well-child visits (n = 271), and a sample of caregivers who attended treatment with a child displaying PSB (n = 110). Using these samples, various forms of reliability and validity were computed to estimate the psychometric characteristics of the ASB-C. We have placed all of the conceptual and analytic details and underpinnings in a later chapter to facilitate a more applied review of the measure's content, administration, and use. Those interested in these more technical aspects are referred to *Chapter 7: Psychometric Properties and Standardization*, and the appendices.

A Note on Response Format and Period of Assessment

Throughout the development of the ASB-C, the team repeatedly grappled with two questions. The first pertained to the period of time over which caregivers are asked to recall and report on the behaviors of the child. The timeframe must be long enough to adequately capture concerning behaviors while also short enough to allow for the observation of meaningful change. For instance, treatment for children with PSB is often three to six months in length; a timeframe of six months for the measure would prohibit monitoring of treatment outcome. The desire to

develop a measure with maximum clinical utility led to the decision to ask caregivers to report on the frequency of behaviors over the past month. However, recognizing that it is valuable in many cases to assess behavior over a longer period of time, the team developed an alternative version of the ASB-C that supplements the standard form with an additional column asking whether the behavior occurred over the prior 6 months. This version of the measure is discussed in *Chapter 6: The ASB-C Extended Version (ASB-CE).*

Having decided on the length of time for the assessment, the team considered the most helpful forms of response options. From clinical experience, the team determined that it is particularly informative to know if a given behavior was an isolated incident (i.e., occurred once) or had been repeated. This led to further specification that it is helpful to distinguish between those cases where a behavior occurred only a few times (2-4 times) or was more repetitive and may represent an established pattern of behavior. In considering these options, the team noted that caregivers do not typically have much trouble recalling the frequency of a behavior if it occurred a limited number of times (e.g., once, twice, three times), but have more difficulty remembering the precise number of times as the frequency increases (e.g., did it happen 11 or 12 times?). As a result, the team developed the following anchors for caregiver response options: (0) Never, (1) Once, (2) 2-4 times, (3) 5-10 times, (4) More than 10 times. Reporting the frequency of a given behavior is a common response method for measures that assess discrete occurrences of behavior (e.g., substance use, sexual activity) and reduces subjectivity that might impact ratings using options such as “sometimes” or “almost always.” This 5-anchor response scale carries the benefit of having an absolute zero (i.e., 0 means the absence of the given behavior) and respects the feedback of some caregivers in the early pilot work who suggested that an original 7-point scale presented too many options.

CHAPTER 3:
Administration of the ASB-C

Appropriate Populations

The ASB-C is intended for use with children between the ages of 3 and 12 years (inclusive) to assess the frequency and severity of sexual behaviors, including the identification of PSB. Standard use the ASB-C with youth outside of this age range is not recommended as no psychometric norms were collected with older or younger youth and developmental expectations are likely to differ significantly. Caution is further warranted when applying measures to children with significant cognitive impairments (e.g., intellectual disability) and/or developmental disabilities (e.g., autism spectrum disorder [ASD]) given established psychometric shortcomings and potential to over-diagnosis, as found in research on widely utilized measures of childhood emotional and behavioral concerns, such as the CBCL or the SDQ (Dovgan et al., 2019; Halvorsen et al., 2023). The current normative sample of 3-12-year-olds for the ASB-C does not include children with significant cognitive impairment or developmental disabilities. Thus, the use of the ASB-C with these populations should rely on examination of item-level content until appropriate norms are available.

The ASB-C should be completed by a caregiver who has spent a significant (i.e., at least 20 hours per week) amount of time with the child over the past month (i.e., minimum of the past 30 days in a caregiving role). We encourage the respondent to report on behaviors that they observed; however, in many cases the behavior is reported from a second party (e.g., teacher, babysitter) who is not available to complete the measure. In these instances, it is allowable for

the respondent to include these reports to improve the accuracy of the assessment. Nevertheless, a respondent who spends limited time with the child (e.g., every other weekend, less than an hour per day) may not have sufficient exposure to the child to provide a suitable report. In such instances, there is limited confidence in the validity of the respondent's report.

Some clinicians report discomfort or hesitation in administering a measure of sexual behavior as they are unsure how the caregiver might respond and/or fear the caregiver may question the appropriateness. We find it is often helpful to preface the administration of the measure in some way. One option is to assure the caregiver that the clinician is interested in performing a comprehensive assessment of potential emotional and behavioral concerns; although many caregivers will report no significant concerns related to sexual behavior, some caregivers realize they have concerns after completing this measure. In this way, administration of the ASB-C is merely in the interests of being thorough. Another option is to highlight for the caregiver that PSB may be relevant given other presenting concerns already known regarding the child. For instance, PSB often co-occurs with other behavioral problems or after an experience of sexual abuse. As such, it is relevant for the clinician to assess. In addition, it may be helpful to re-state confidentiality and privacy policies to address any concerns the caregiver might have about who will have access to responses, remembering that sexual contact between minors is a mandated reporting issue in some areas. It is prudent to stay familiar with the state and jurisdiction laws and practices, which can change over time (e.g., recent "raise the age" efforts have increased the lower age limit of crimes in some states). Finally, it is important to remember that children presenting for treatment of PSB are already known to have some knowledge or experience with sexual topics; it should not be surprising to the caregiver that a clinician would

like to have a more complete picture of the behaviors displayed. This rationale may be used in such cases.

Administration

The ASB-C was designed to be relatively straightforward to administer. Nonetheless, as with any measure, the administrator wants to ensure that the caregiver completing the form adequately understands the instructions. The ASB-C has two parts. The instructions for the first part of the ASB-C, designed to assess the frequency of different behaviors, are reprinted here:

> *The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the* ***PAST MONTH*** *using the scale provided below.*

It may be advantageous to review the instructions with the caregiver to ensure understanding. There are a few aspects of these instructions worth highlighting. First, the term "private parts" refers specifically to the genital area of an individual, with specific body parts (i.e., penis, vagina, or rectum) used to define the term. Breasts are not included within the description of "private parts" for multiple reasons. Behaviors involving breasts may be developmentally normative at some ages and be observed with frequencies quite different than behaviors focused on the genital area. For instance, a 3-year-old child touching a woman's breast 2-4 times (response option "2") may not be particularly concerning, but that same child deliberately touching the genital area of an adult 2-4 times may fall outside of developmental expectations. In addition, some items that are relevant to body parts within the genital area may not be relevant to breasts (e.g., items asking about the insertion of objects). Throughout the ASB-

C, items are written with specific reference to the body parts of interest; some items identify "private parts," some items refer specifically to "breasts," and other items identify "breasts or private parts."

Second, the phrase "sexual acts" is left intentionally broad as not every behavior falling under this category can be defined here. Although the items were written with the goal of reducing subjectivity to the extent possible, a certain level of variability is expected when caregivers are asked to consider whether or not a given behavior is sexual. If directly asked by a caregiver for further specification of the term "sexual acts," the administrator is advised to respond by encouraging the caregiver to use their discretion as to whether they believe the acts in question qualify as "sexual."

Third, the anchors for each of the five response options are frequencies and, therefore, are mutually exclusive. However, caregivers may be uncertain of the number of times a behavior has occurred and, thus, be unsure of how to answer an item. This may lead to a desire to endorse two response options or a belief that the correct frequency lies between two options. If the caregiver asks how to respond in this situation, the administrator is advised to respond: "*Please give your best estimate*." Alternatively, a caregiver may believe that the behavior has occurred more times than they have directly observed or been told about by another individual. In such instances, the administrator is advised to respond: "*Please give your best estimate to report the number of times it is known to have occurred*."

The second part of the ASB-C is designed to provide additional information to better specify the nature of any sexual behavior endorsed and to help with treatment planning. Although the second part of the ASB-C is also straightforward, it may be helpful to review two components of it with the caregivers. First, if the caregiver answers "0" (Never) to all of the

items in the first part, then there is no need to complete this second part. Second, for the first two items in this part (A & B), they may check all the options that apply. The last item (C) is mutually exclusive and the caregiver can only endorse one option. The directions for the second part of the ASB-C are reprinted here:

> *The questions below are to help us better understand the behaviors you described above. Note: If you answered "0" (Never) to all the questions above, you do not need to complete the section below.*

This second part of the ASB-C is designed to assess the context of any endorsed sexual behavior to aid in the development of safety plans, identify other children who may benefit from services, and/or indicate additional topics for discussion with the caregiver.

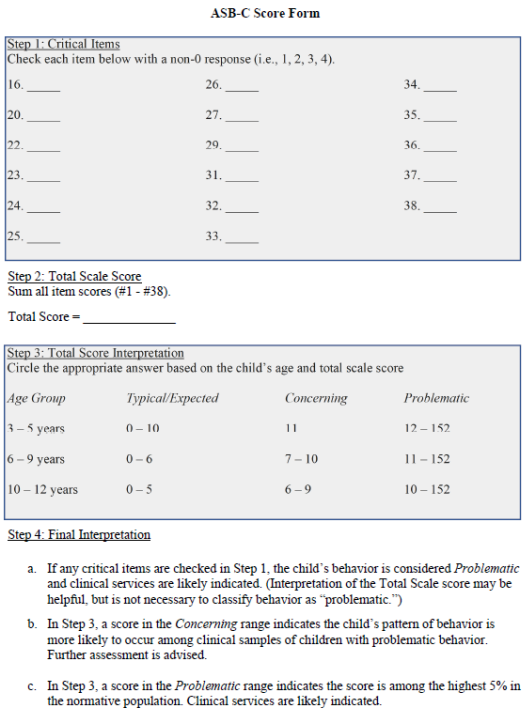
Professional Requirements

As noted, the ASB-C was designed to be a straightforward measure to administer and score, and these functions can be performed by any individual who sufficiently understands such activities in a professional context. Interpretation of the ASB-C for clinical purposes, however, should only be done by an individual with appropriate training in a mental health discipline, such as psychology, psychiatry, social work, or counseling. Practice should follow professional ethics, state licensing requirements, and state and federal mandates. The ASB-C is a tool for obtaining clinical information and other forms of information (e.g., clinical interviews, measures of trauma and other presenting concerns, and collateral information from community partners such as child welfare and the schools) are relevant for the assessment and treatment of children with PSB. The clinician is urged to use the ASB-C in conjunction with other indicated clinical methods.

CHAPTER 4:
Scoring of the ASB-C

The ASB-C should be easy to score and a companion "ASB-C Score Form" is available to streamline the process. As mentioned previously, some individual behaviors are rare, but are a cause for concern. The accumulation of diverse and frequent behaviors may also reach a point that the child's display of sexualized behavior exceeds what is typical for a given age. Scoring of the ASB-C accounts for both of these situations (i.e., documenting rare or severe individual behaviors, identifying an accumulation of behaviors that goes beyond developmental expectations). The ASB-C Score Form is pictured in Figure 4.1. (also see Appendix E).

Figure 4.1: The ASB-C Score Form



ASB-C Score Form

Step 1: Critical Items
Check each item below with a non-0 response (i.e., 1, 2, 3, 4).

16. ____	26. ____	34. ____
20. ____	27. ____	35. ____
22. ____	29. ____	36. ____
23. ____	31. ____	37. ____
24. ____	32. ____	38. ____
25. ____	33. ____	

Step 2: Total Scale Score
Sum all item scores (#1 - #38).

Total Score = _____

Step 3: Total Score Interpretation
Circle the appropriate answer based on the child's age and total scale score

Age Group	*Typical/Expected*	*Concerning*	*Problematic*
3 – 5 years	0 – 10	11	12 – 152
6 – 9 years	0 – 6	7 – 10	11 – 152
10 – 12 years	0 – 5	6 – 9	10 – 152

Step 4: Final Interpretation

a. If any critical items are checked in Step 1, the child's behavior is considered *Problematic* and clinical services are likely indicated. (Interpretation of the Total Scale score may be helpful, but is not necessary to classify behavior as "problematic.")

b. In Step 3, a score in the *Concerning* range indicates the child's pattern of behavior is more likely to occur among clinical samples of children with problematic behavior. Further assessment is advised.

c. In Step 3, a score in the *Problematic* range indicates the score is among the highest 5% in the normative population. Clinical services are likely indicated.

The first task in scoring the ASB-C is to identify **whether the respondent endorsed any of the "critical items."** In step 1, the clinician reviews the completed ASB-C and places a check mark next to each item endorsed. Place a check for any item rated 1, 2, 3, or 4, as any endorsement of the item is quite rare in the normative population and signals a cause for concern.

Step 2 in scoring the ASB-C is to calculate a sum score for the Total Scale by adding the frequency responses for all 38 items. This Total Scale score is then interpreted by circling the appropriate score range given the child's age in step 3. This will indicate for the clinician whether the child's score is in the *Typical/Expected, Concerning*, or *Problematic* range. The meaning behind these terms and how to interpret the obtained score is discussed in the next chapter. The examples below demonstrate a completed ASB-C and a completed ASB-C Score Form.

In the example in Figure 4.2, the caregiver did not endorse any of the critical items and, therefore, all of those items are left blank in Step 1 on the ASB-C Score Form. Summing the scores for all 38 items resulted in a Total Scale score of 10, which is written on the line in Step 2. Given that the child is 4-years-old, the range of 0-10 for the age group "3-5 years" is appropriately circled in Step 3. As can be seen, this suggests that the child's score falls in the *Typical/Expected* range.

In the example in Figure 4.3, the caregiver reported the child displayed two behaviors that are deemed "critical items" (#23 and #38). As such, both of these items are checked in Step 1. The sum of the scores of all items on the ASB-C yields a total score of 15 (Step 2). Given that the child was 10 years old, the score of 15 falls within the score range of 10-152 on the line for the 10-12 years age group, which is identified here as *Problematic*.

Figure 4.2: Example Scoring of the ASB-C for a 4-Year-Old

ASB-C

The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the **PAST MONTH** using the scale provided.

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
1.	Stands or sits too close to others.	0	1	(2)	3	4
2.	Hugs people they do not know well.	0	(1)	2	3	4
3.	Kisses people they do not know well.	(0)	1	2	3	4
4.	Touches or tries to touch the breasts of others.	0	(1)	2	3	4
5.	Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	0	1	(2)	3	4
6.	Asks questions about private parts and/or sexual acts to people other than a trusted adult.	(0)	1	2	3	4
7.	Views non-sexual things or topics in a sexual way.	0	(1)	2	3	4
8.	Uses the internet to seek out information on sexual topics.	(0)	1	2	3	4
9.	Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	0	1	(2)	3	4
10.	Uses sexual words in an insulting, disrespectful, and/or suggestive way.	(0)	1	2	3	4
11.	Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	(0)	1	2	3	4
12.	Moves, dances, or makes hand gestures that are sexually suggestive.	(0)	1	2	3	4
13.	Looks at or tries to look at others who are nude, undressing, and/or toileting.	(0)	1	2	3	4
14.	Looks at or tries to look at people engaged in sexual acts.	(0)	1	2	3	4
15.	Looks at pictures or videos that show nudity or sexual acts.	(0)	1	2	3	4
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	(0)	1	2	3	4
17.	Touches or rubs own private parts when ***alone***.	(0)	1	2	3	4
18.	Touches or rubs private parts when around ***other people***.	(0)	1	2	3	4
19.	Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	(0)	1	2	3	4
20.	Inserts or tries to insert objects inside ***own*** private parts.	(0)	1	2	3	4
21.	Shows own private parts to others.	0	(1)	2	3	4
22.	Shows picture(s) of their own or other people's private parts to others.	(0)	1	2	3	4
23.	Asks others to show their private parts or engage in sexual acts while talking **in-person**.	(0)	1	2	3	4

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	(0)	1	2	3	4
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).	(0)	1	2	3	4
26.	Coerces others to send sexual pictures or videos. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
27.	Threatens to share sexual pictures or videos of others.	(0)	1	2	3	4
28.	Strokes, massages, or caresses the bodies of others.	(0)	1	2	3	4
29.	Rubs private parts on other people.	(0)	1	2	3	4
30.	Slaps or pokes the buttocks of others.	(0)	1	2	3	4
31.	Touches or tries to touch the private parts of others.	(0)	1	2	3	4
32.	Puts mouth on the breasts or private parts of others.	(0)	1	2	3	4
33.	Inserts or tries to insert objects in ***another child's*** private parts.	(0)	1	2	3	4
34.	Tries to undress others against their will.	(0)	1	2	3	4
35.	Plans to get others to engage in sexual behavior.	(0)	1	2	3	4
36.	Coerces others to engage in sexual behavior. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
37.	Performs sexual behaviors with an animal.	(0)	1	2	3	4
38.	Continues to engage in sexual behavior after being told to stop.	(0)	1	2	3	4

***Please tell us of any other sexual behaviors your child has displayed that were not mentioned above:

_____

***The questions below are to help us better understand the behaviors you described above.
Note: *If you answered "0" (Never) to all the questions above, you do not need to complete the section below.*

A. With whom did your child engage in any of the behaviors above (check all that apply):

☒ Children who live in the same home (such as siblings) ☐ Strangers or people they do not know well
☐ Children who do not live in the same home (such as cousins) ☐ Neighbor(s)
☐ Children at school (such as schoolmates) ☒ Adult(s)
☐ Children with developmental delays or disabilities ☐ Children who are younger
☐ Children with another vulnerability (please describe): _____

B. Where did the behaviors you reported above occur (check all that apply):

☒ Home ☐ Neighbor's house ☐ Public setting (such as stores)
☐ School/preschool/school bus ☐ Childcare provider ☐ Outside (such as a playground)
☐ Other (please describe): _____

C. During any of the behaviors you reported above, did your child use coercion, such as force, threats, pressure, bribery, and/or trickery?

☒ No ☐ Yes (please describe): _____

ASB-C Score Form

Step 1: Critical Items
Check each item below with a non-0 response (i.e., 1, 2, 3, 4).

16. _____	26. _____	34. _____
20. _____	27. _____	35. _____
22. _____	29. _____	36. _____
23. _____	31. _____	37. _____
24. _____	32. _____	38. _____
25. _____	33. _____	

Step 2: Total Scale Score
Sum all item scores (#1 - #38).

Total Score = 10

Step 3: Total Score Interpretation
Circle the appropriate answer based on the child's age and total scale score

Age Group	*Typical/Expected*	*Concerning*	*Problematic*
3 – 5 years	(0 – 10)	11	12 – 152
6 – 9 years	0 – 6	7 – 10	11 – 152
10 – 12 years	0 – 5	6 – 9	10 – 152

Step 4: Final Interpretation

a. If any critical items are checked in Step 1, the child's behavior is considered *Problematic* and clinical services are likely indicated. (Interpretation of the Total Scale score may be helpful, but is not necessary to classify behavior as "problematic.")

b. In Step 3, a score in the *Concerning* range indicates the child's pattern of behavior is more likely to occur among clinical samples of children with problematic behavior. Further assessment is advised.

c. In Step 3, a score in the *Problematic* range indicates the score is among the highest 5% in the normative population. Clinical services are likely indicated.

Figure 4.3: Example Scoring of the ASB-C for a 10-Year-Old

ASB-C

ASB-C

The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the **PAST MONTH** using the scale provided.

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
1.	Stands or sits too close to others.	(0)	1	2	3	4
2.	Hugs people they do not know well.	(0)	1	2	3	4
3.	Kisses people they do not know well.	(0)	1	2	3	4
4.	Touches or tries to touch the breasts of others.	(0)	1	2	3	4
5.	Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	(0)	1	2	3	4
6.	Asks questions about private parts and/or sexual acts to people other than a trusted adult.	(0)	1	2	3	4
7.	Views non-sexual things or topics in a sexual way.	0	1	(2)	3	4
8.	Uses the internet to seek out information on sexual topics.	0	1	(2)	3	4
9.	Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	0	1	(2)	3	4
10.	Uses sexual words in an insulting, disrespectful, and/or suggestive way.	0	1	(2)	3	4
11.	Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	(0)	1	2	3	4
12.	Moves, dances, or makes hand gestures that are sexually suggestive.	(0)	1	2	3	4
13.	Looks at or tries to look at others who are nude, undressing, and/or toileting.	(0)	1	2	3	4
14.	Looks at or tries to look at people engaged in sexual acts.	(0)	1	2	3	4
15.	Looks at pictures or videos that show nudity or sexual acts.	0	1	(2)	3	4
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	(0)	1	2	3	4
17.	Touches or rubs own private parts when ***alone***.	(0)	1	2	3	4
18.	Touches or rubs private parts when around ***other people***.	(0)	1	2	3	4
19.	Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	(0)	1	2	3	4
20.	Inserts or tries to insert objects inside ***own*** private parts.	(0)	1	2	3	4
21.	Shows own private parts to others.	(0)	1	2	3	4
22.	Shows picture(s) of their own or other people's private parts to others.	(0)	1	2	3	4
23.	Asks others to show their private parts or engage in sexual acts while talking **in-person**.	0	(1)	2	3	4

ASB-C

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	(0)	1	2	3	4
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).	(0)	1	2	3	4
26.	Coerces others to send sexual pictures or videos. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
27.	Threatens to share sexual pictures or videos of others.	(0)	1	2	3	4
28.	Strokes, massages, or caresses the bodies of others.	(0)	1	2	3	4
29.	Rubs private parts on other people.	(0)	1	2	3	4
30.	Slaps or pokes the buttocks of others.	0	1	(2)	3	4
31.	Touches or tries to touch the private parts of others.	(0)	1	2	3	4
32.	Puts mouth on the breasts or private parts of others.	(0)	1	2	3	4
33.	Inserts or tries to insert objects in ***another child's*** private parts.	(0)	1	2	3	4
34.	Tries to undress others against their will.	(0)	1	2	3	4
35.	Plans to get others to engage in sexual behavior.	(0)	1	2	3	4
36.	Coerces others to engage in sexual behavior. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
37.	Performs sexual behaviors with an animal.	(0)	1	2	3	4
38.	Continues to engage in sexual behavior after being told to stop.	0	1	(2)	3	4

***Please tell us of any other sexual behaviors your child has displayed that were not mentioned above:

***The questions below are to help us better understand the behaviors you described above.
Note: *If you answered "0" (Never) to all the questions above, you do not need to complete the section below.*

A. With whom did your child engage in any of the behaviors above (check all that apply):

- ☐ Children who live in the same home (such as siblings)
- ☒ Children who do not live in the same home (such as cousins)
- ☒ Children at school (such as schoolmates)
- ☐ Children with developmental delays or disabilities
- ☐ Children with another vulnerability (please describe): _____
- ☐ Strangers or people they do not know well
- ☐ Neighbor(s)
- ☐ Adult(s)
- ☐ Children who are younger

B. Where did the behaviors you reported above occur (check all that apply):

- ☐ Home
- ☒ School/preschool/school bus
- ☐ Other (please describe): _____
- ☒ Neighbor's house
- ☐ Childcare provider
- ☐ Public setting (such as stores)
- ☐ Outside (such as a playground)

C. During any of the behaviors you reported above, did your child use coercion, such as force, threats, pressure, bribery, and/or trickery?

- ☒ No
- ☐ Yes (please describe): _____

ASB-C Score Form

Step 1: Critical Items
Check each item below with a non-0 response (i.e., 1, 2, 3, 4).

16. ____	26. ____	34. ____
20. ____	27. ____	35. ____
22. ____	29. ____	36. ____
23. ✖	31. ____	37. ____
24. ____	32. ____	38. ✖
25. ____	33. ____	

Step 2: Total Scale Score
Sum all item scores (#1 - #38).

Total Score = 15

Step 3: Total Score Interpretation
Circle the appropriate answer based on the child's age and total scale score

Age Group	*Typical/Expected*	*Concerning*	*Problematic*
3 – 5 years	0 – 10	11	12 – 152
6 – 9 years	0 – 6	7 – 10	11 – 152
10 – 12 years	0 – 5	6 – 9	(10 – 152)

Step 4: Final Interpretation

a. If any critical items are checked in Step 1, the child's behavior is considered *Problematic* and clinical services are likely indicated. (Interpretation of the Total Scale score may be helpful, but is not necessary to classify behavior as "problematic.")

b. In Step 3, a score in the *Concerning* range indicates the child's pattern of behavior is more likely to occur among clinical samples of children with problematic behavior. Further assessment is advised.

c. In Step 3, a score in the *Problematic* range indicates the score is among the highest 5% in the normative population. Clinical services are likely indicated.

CHAPTER 5:
Interpretation and Use of the ASB-C

Although scoring the ASB-C is a straightforward process, interpretation is a multi-step procedure and often requires the clinician to collect additional information to fully understand the behaviors endorsed. This chapter reviews the interpretation of the ASB-C, relying on the Score Form described in the previous chapter, and provides several examples of ASB-C interpretation. This chapter concludes with a discussion of the different uses for the ASB-C.

Profile Interpretation

Critical Items. Interpreting the ASB-C begins by examining the caregiver's responses to the 17 "critical items." These items were each endorsed by 1.0% or less of the normative sample, indicating their extreme rarity in the general population. Clinical experience suggests that the behaviors captured by these items represent a clear and significant risk for exploitation and/or injury to an individual, whether physical or emotional/psychological. Although it is possible these behaviors may not recur, each of these behaviors are well outside of developmental expectations for the 3 to 12 years age range. Any endorsement of a "critical item," regardless of frequency, signifies that clinical attention is warranted.

Total Scale Score. The sum of scores for all 38 items provides an indication of the diversity and frequency of sexual behaviors observed by the caregiver. Interpretation of this score, stratified based on age, utilizes three qualitative ranges: *Typical/Expected*, *Concerning*, and *Problematic*. The cutoff point separating the *Typical/Expected* range from the *Concerning* range was derived by comparing scores from the normative sample to scores from a clinical

sample of children seeking treatment for PSB. If a child's score falls in the *Concerning* range (or *Problematic* range), this denotes that the score is more likely to reflect those obtained from clinical cases than cases drawn from the general population. Using percentile conversions, cutoff scores for the *Concerning* range are at approximately the 85th percentile in the normative sample. The cutoff score for the *Problematic* range identifies the point at which the score crosses into the 95% percentile of scores when using the normative sample for comparison. In other words, the child's score is higher than 95% of the scores reported for children in the normative sample. The statistical analyses performed to identify these cutoff scores are detailed in Chapter 7.

Individual Items and Follow-Up Questions. Regardless of how a child scores on the ASB-C, it is recommended clinicians examine all endorsed items and ask appropriate follow-up questions of the caregiver. The qualitative descriptors provided above (i.e., *Typical/Expected*, *Concerning*, *Problematic*) are attempts to provide clinically useful labels for statistically-derived categories. It is possible that a child receiving a score in the *Concerning* range, for instance, is not actually displaying PSB. Similarly, a score in the *Concerning* range may also signify significant behavioral problems that require attention. Alternatively, a significant score on the ASB-C does not provide any information as to the nature of the child's behaviors (e.g., self-focused, electronic/online, interpersonally intrusive). By reviewing the endorsed items with a caregiver, the clinician can more definitively assess the child's behaviors and the need for clinical services. Several examples of this process are provided below.

Examples of ASB-C Interpretation

Figure 5.1 provides a scored ASB-C for a 4-year-old child (note this is the same ASB-C depicted in the previous chapter as Figure 4.2). None of the "critical items" are checked on the score sheet and the child's Total Scale score falls within the *Typical/Expected* range for ages 3-5

years. As such, there is no evidence that the child is displaying PSB. Nonetheless, it is good practice to review the items of the measure to ascertain the types of behaviors reported by the caregiver. In this case, the caregiver endorsed the child performing behaviors such as "Stands or sits too close to others," "Hugs people they do not know well," and "Touches or tries to touch the breasts of others." These types of boundary violations are not uncommon for preschoolers and the child is showing these behaviors infrequently. The remaining endorsed items suggest irregular instances of asking or talking about topics that may be sexual in nature. Again, these types of behaviors and the frequency reported are not altogether unusual for this age. While the results of the ASB-C do not suggest that clinical responses for the child is required, the nature of the referral, questions of the caregiver, and context are important considerations for planning next steps. For example, the questions and concerns of the caregivers may suggest that the provision of education about sexual development and strategies to promote healthy behaviors with the caregivers would be beneficial.

Figure 5.2 is an ASB-C completed for a 5-year-old child. The score form shows two "critical items" endorsed by the caregiver (#32 and #38) and a total score of 25, which falls in the *Problematic* range for children between the ages of 3 and 5 years. Clearly, this child is displaying PSB. Reviewing the individual items demonstrates the nature of his problematic behavior. The "critical item" #32 suggests that at least once in the past month the child was observed putting his mouth on the breast or private parts of another individual. Other boundary problems are visible, including repeated attempts to touch breasts (#4), frequently asking questions about sexual topics to trusted adults (#5) and at least once asking such questions to someone who was not a trusted adult (#6), and frequently attempting to look at others who are nude or undressing. The "critical item" #38 suggests that caregiver attempts to reduce the

Figure 5.1: Example Interpretation of the ASB-C for a 4-Year-Old

ASB-C

ASB-C

The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the **PAST MONTH** using the scale provided.

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
1.	Stands or sits too close to others.	0	1	(2)	3	4
2.	Hugs people they do not know well.	0	(1)	2	3	4
3.	Kisses people they do not know well.	(0)	1	2	3	4
4.	Touches or tries to touch the breasts of others.	0	(1)	2	3	4
5.	Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	0	1	(2)	3	4
6.	Asks questions about private parts and/or sexual acts to people other than a trusted adult.	(0)	1	2	3	4
7.	Views non-sexual things or topics in a sexual way.	0	(1)	2	3	4
8.	Uses the internet to seek out information on sexual topics.	(0)	1	2	3	4
9.	Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	0	1	(2)	3	4
10.	Uses sexual words in an insulting, disrespectful, and/or suggestive way.	(0)	1	2	3	4
11.	Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	(0)	1	2	3	4
12.	Moves, dances, or makes hand gestures that are sexually suggestive.	(0)	1	2	3	4
13.	Looks at or tries to look at others who are nude, undressing, and/or toileting.	(0)	1	2	3	4
14.	Looks at or tries to look at people engaged in sexual acts.	(0)	1	2	3	4
15.	Looks at pictures or videos that show nudity or sexual acts.	(0)	1	2	3	4
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	(0)	1	2	3	4
17.	Touches or rubs own private parts when ***alone***.	(0)	1	2	3	4
18.	Touches or rubs private parts when around ***other people***.	(0)	1	2	3	4
19.	Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	(0)	1	2	3	4
20.	Inserts or tries to insert objects inside ***own*** private parts.	(0)	1	2	3	4
21.	Shows own private parts to others.	0	(1)	2	3	4
22.	Shows picture(s) of their own or other people's private parts to others.	(0)	1	2	3	4
23.	Asks others to show their private parts or engage in sexual acts while talking ***in-person***.	(0)	1	2	3	4

ASB-C

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	(0)	1	2	3	4
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).	(0)	1	2	3	4
26.	Coerces others to send sexual pictures or videos. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
27.	Threatens to share sexual pictures or videos of others.	(0)	1	2	3	4
28.	Strokes, massages, or caresses the bodies of others.	(0)	1	2	3	4
29.	Rubs private parts on other people.	(0)	1	2	3	4
30.	Slaps or pokes the buttocks of others.	(0)	1	2	3	4
31.	Touches or tries to touch the private parts of others.	(0)	1	2	3	4
32.	Puts mouth on the breasts or private parts of others.	(0)	1	2	3	4
33.	Inserts or tries to insert objects in ***another child's*** private parts.	(0)	1	2	3	4
34.	Tries to undress others against their will.	(0)	1	2	3	4
35.	Plans to get others to engage in sexual behavior.	(0)	1	2	3	4
36.	Coerces others to engage in sexual behavior. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
37.	Performs sexual behaviors with an animal.	(0)	1	2	3	4
38.	Continues to engage in sexual behavior after being told to stop.	(0)	1	2	3	4

***Please tell us of any other sexual behaviors your child has displayed that were not mentioned above:

_____

***The questions below are to help us better understand the behaviors you described above.
Note: *If you answered "0" (Never) to all the questions above, you do not need to complete the section below.*

A. With whom did your child engage in any of the behaviors above (check all that apply):

- ☒ Children who live in the same home (such as siblings)
- ☐ Children who do not live in the same home (such as cousins)
- ☐ Children at school (such as schoolmates)
- ☐ Children with developmental delays or disabilities
- ☐ Children with another vulnerability (please describe): _____
- ☐ Strangers or people they do not know well
- ☐ Neighbor(s)
- ☒ Adult(s)
- ☐ Children who are younger

B. Where did the behaviors you reported above occur (check all that apply):

- ☒ Home
- ☐ School/preschool/school bus
- ☐ Other (please describe): _____
- ☐ Neighbor's house
- ☐ Childcare provider
- ☐ Public setting (such as stores)
- ☐ Outside (such as a playground)

C. During any of the behaviors you reported above, did your child use coercion, such as force, threats, pressure, bribery, and/or trickery?

- ☒ No
- ☐ Yes (please describe): _____

ASB-C Score Form

Step 1: Critical Items
Check each item below with a non-0 response (i.e., 1, 2, 3, 4).

16. _____	26. _____	34. _____
20. _____	27. _____	35. _____
22. _____	29. _____	36. _____
23. _____	31. _____	37. _____
24. _____	32. _____	38. _____
25. _____	33. _____	

Step 2: Total Scale Score
Sum all item scores (#1 - #38).

Total Score = 10

Step 3: Total Score Interpretation
Circle the appropriate answer based on the child's age and total scale score

Age Group	*Typical/Expected*	*Concerning*	*Problematic*
3 – 5 years	(0 – 10)	11	12 – 152
6 – 9 years	0 – 6	7 – 10	11 – 152
10 – 12 years	0 – 5	6 – 9	10 – 152

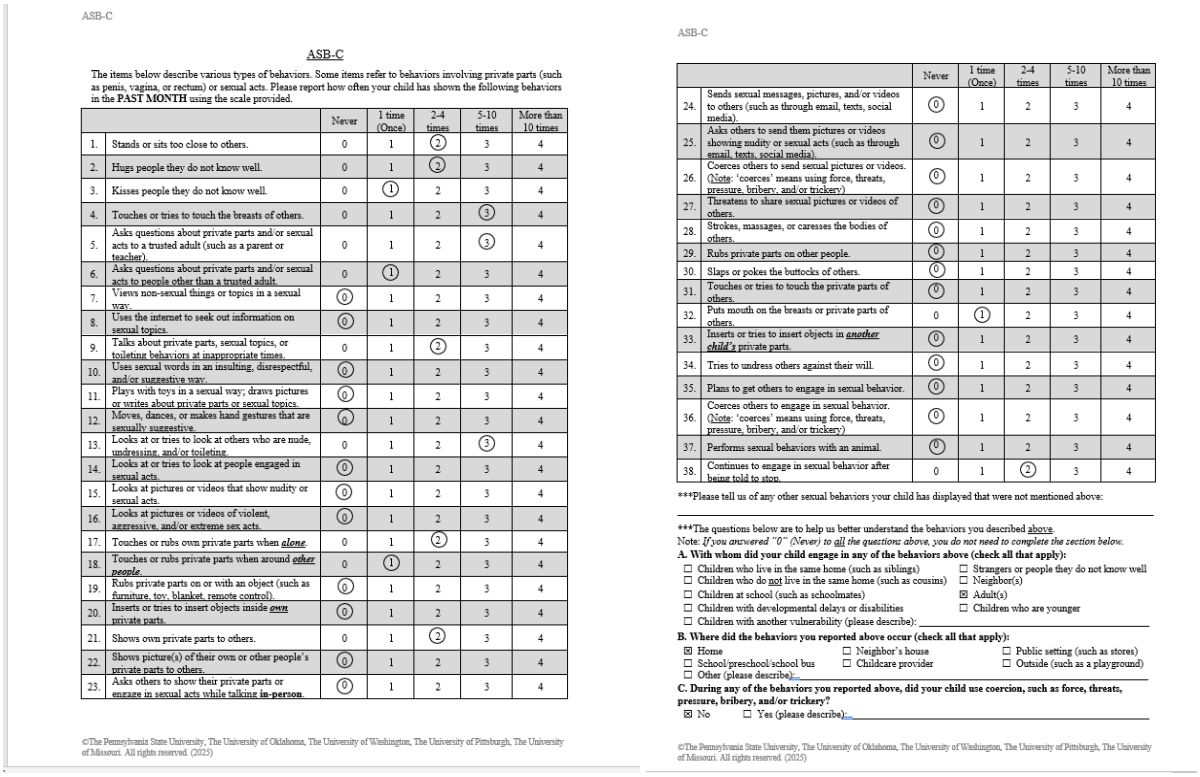
Step 4: Final Interpretation

a. If any critical items are checked in Step 1, the child's behavior is considered *Problematic* and clinical services are likely indicated. (Interpretation of the Total Scale score may be helpful, but is not necessary to classify behavior as "problematic.")

b. In Step 3, a score in the *Concerning* range indicates the child's pattern of behavior is more likely to occur among clinical samples of children with problematic behavior. Further assessment is advised.

c. In Step 3, a score in the *Problematic* range indicates the score is among the highest 5% in the normative population. Clinical services are likely indicated.

Figure 5.2: Example Interpretation of the ASB-C for a 5-Year-Old



ASB-C

ASB-C

The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the **PAST MONTH** using the scale provided.

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
1.	Stands or sits too close to others.	0	1	(2)	3	4
2.	Hugs people they do not know well.	0	1	(2)	3	4
3.	Kisses people they do not know well.	0	(1)	2	3	4
4.	Touches or tries to touch the breasts of others.	0	1	2	(3)	4
5.	Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	0	1	2	(3)	4
6.	Asks questions about private parts and/or sexual acts to people other than a trusted adult.	0	(1)	2	3	4
7.	Views non-sexual things or topics in a sexual way.	(0)	1	2	3	4
8.	Uses the internet to seek out information on sexual topics.	(0)	1	2	3	4
9.	Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	0	1	(2)	3	4
10.	Uses sexual words in an insulting, disrespectful, and/or suggestive way.	(0)	1	2	3	4
11.	Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	(0)	1	2	3	4
12.	Moves, dances, or makes hand gestures that are sexually suggestive.	(0)	1	2	3	4
13.	Looks at or tries to look at others who are nude, undressing, and/or toileting.	0	1	2	(3)	4
14.	Looks at or tries to look at people engaged in sexual acts.	(0)	1	2	3	4
15.	Looks at pictures or videos that show nudity or sexual acts.	(0)	1	2	3	4
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	(0)	1	2	3	4
17.	Touches or rubs own private parts when ***alone***.	0	1	(2)	3	4
18.	Touches or rubs private parts when around ***other people***.	0	(1)	2	3	4
19.	Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	(0)	1	2	3	4
20.	Inserts or tries to insert objects inside ***own*** private parts.	(0)	1	2	3	4
21.	Shows own private parts to others.	0	1	(2)	3	4
22.	Shows picture(s) of their own or other people's private parts to others.	(0)	1	2	3	4
23.	Asks others to show their private parts or engage in sexual acts while talking **in-person**.	(0)	1	2	3	4

ASB-C

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	(0)	1	2	3	4
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).	(0)	1	2	3	4
26.	Coerces others to send sexual pictures or videos. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
27.	Threatens to share sexual pictures or videos of others.	(0)	1	2	3	4
28.	Strokes, massages, or caresses the bodies of others.	(0)	1	2	3	4
29.	Rubs private parts on other people.	(0)	1	2	3	4
30.	Slaps or pokes the buttocks of others.	(0)	1	2	3	4
31.	Touches or tries to touch the private parts of others.	(0)	1	2	3	4
32.	Puts mouth on the breasts or private parts of others.	0	(1)	2	3	4
33.	Inserts or tries to insert objects in ***another child's*** private parts.	(0)	1	2	3	4
34.	Tries to undress others against their will.	(0)	1	2	3	4
35.	Plans to get others to engage in sexual behavior.	(0)	1	2	3	4
36.	Coerces others to engage in sexual behavior. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
37.	Performs sexual behaviors with an animal.	(0)	1	2	3	4
38.	Continues to engage in sexual behavior after being told to stop.	0	1	(2)	3	4

***Please tell us of any other sexual behaviors your child has displayed that were not mentioned above:

***The questions below are to help us better understand the behaviors you described above.
Note: *If you answered "0" (Never) to all the questions above, you do not need to complete the section below.*

A. With whom did your child engage in any of the behaviors above (check all that apply):

- ☐ Children who live in the same home (such as siblings)
- ☐ Children who do not live in the same home (such as cousins)
- ☐ Children at school (such as schoolmates)
- ☐ Children with developmental delays or disabilities
- ☐ Children with another vulnerability (please describe): _____
- ☐ Strangers or people they do not know well
- ☐ Neighbor(s)
- ☒ Adult(s)
- ☐ Children who are younger

B. Where did the behaviors you reported above occur (check all that apply):

- ☒ Home
- ☐ School/preschool/school bus
- ☐ Other (please describe): _____
- ☐ Neighbor's house
- ☐ Childcare provider
- ☐ Public setting (such as stores)
- ☐ Outside (such as a playground)

C. During any of the behaviors you reported above, did your child use coercion, such as force, threats, pressure, bribery, and/or trickery?

☒ No ☐ Yes (please describe): _____

ASB-C Score Form

Step 1: Critical Items
Check each item below with a non-0 response (i.e., 1, 2, 3, 4).

16. ____	26. ____	34. ____
20. ____	27. ____	35. ____
22. ____	29. ____	36. ____
23. ____	31. ____	37. ____
24. ____	32. ✖	38. ✖
25. ____	33. ____	

Step 2: Total Scale Score
Sum all item scores (#1 - #38).

Total Score = 25

Step 3: Total Score Interpretation
Circle the appropriate answer based on the child's age and total scale score

Age Group	*Typical/Expected*	*Concerning*	*Problematic*
3 – 5 years	0 – 10	11	(12 – 152)
6 – 9 years	0 – 6	7 – 10	11 – 152
10 – 12 years	0 – 5	6 – 9	10 – 152

Step 4: Final Interpretation

a. If any critical items are checked in Step 1, the child's behavior is considered *Problematic* and clinical services are likely indicated. (Interpretation of the Total Scale score may be helpful, but is not necessary to classify behavior as "problematic.")

b. In Step 3, a score in the *Concerning* range indicates the child's pattern of behavior is more likely to occur among clinical samples of children with problematic behavior. Further assessment is advised.

c. In Step 3, a score in the *Problematic* range indicates the score is among the highest 5% in the normative population. Clinical services are likely indicated.

problematic behavior have been unsuccessful. It will likely be helpful for the clinician to learn more about the contexts of these behaviors including what these attempts to change behavior have included as well as the individual(s) most commonly subjected to the child's behavior.

Figure 5.3 provides a scored ASB-C for a 7-year-old child. The profile here underlines the importance of clinicians reviewing individual items and not merely relying on the determination suggested on the score form. At first blush, the profile suggests potential concerning behavior as the caregiver endorsed one "critical item" (#38) and the Total Scale score is at the high end of the *Concerning* range. However, in reviewing the completed protocol, it becomes difficult to discern the nature of the sexual behavior. Remembering the age of the child, there is nothing particularly problematic with occasionally asking questions to trusted adults (#5), making one comment about private parts or sexual topics in the past month (#9), or touching one's own private parts when alone (#17). Even the endorsed item of trying to look at others nude or undressing (#13) was only reported to have occurred once, which is not outside of normal expectations for a 7-year-old. Collectively, the behaviors endorsed appear to be of low frequency and relatively common for a child of this age. Nonetheless, the one "critical item" identified on the score form suggests that the caregiver frequently attempts to correct the child's behaviors and believes these attempts have been unsuccessful. Rather than the child displaying PSB, it appears the caregiver may be reporting concerns about relatively normative behaviors. Depending on the context and other information, these results suggest a preventative educational approach that provides the family with information about typical child sexual development and strategies to promote healthy decision making, including ways to address their child's questions, as opposed to PSB-focused treatment for the child.

Figure 5.3: Example Interpretation of the ASB-C for a 7-Year-Old

ASB-C

ASB-C

The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the **PAST MONTH** using the scale provided.

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
1.	Stands or sits too close to others.	(0)	1	2	3	4
2.	Hugs people they do not know well.	(0)	1	2	3	4
3.	Kisses people they do not know well.	(0)	1	2	3	4
4.	Touches or tries to touch the breasts of others.	(0)	1	2	3	4
5.	Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	0	1	(2)	3	4
6.	Asks questions about private parts and/or sexual acts to people other than a trusted adult.	(0)	1	2	3	4
7.	Views non-sexual things or topics in a sexual way.	0	(1)	2	3	4
8.	Uses the internet to seek out information on sexual topics.	(0)	1	2	3	4
9.	Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	0	(1)	2	3	4
10.	Uses sexual words in an insulting, disrespectful, and/or suggestive way.	(0)	1	2	3	4
11.	Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	(0)	1	2	3	4
12.	Moves, dances, or makes hand gestures that are sexually suggestive.	(0)	1	2	3	4
13.	Looks at or tries to look at others who are nude, undressing, and/or toileting.	0	(1)	2	3	4
14.	Looks at or tries to look at people engaged in sexual acts.	(0)	1	2	3	4
15.	Looks at pictures or videos that show nudity or sexual acts.	(0)	1	2	3	4
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	(0)	1	2	3	4
17.	Touches or rubs own private parts when ***alone***.	0	1	(2)	3	4
18.	Touches or rubs private parts when around ***other people***.	(0)	1	2	3	4
19.	Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	(0)	1	2	3	4
20.	Inserts or tries to insert objects inside ***own*** private parts.	(0)	1	2	3	4
21.	Shows own private parts to others.	(0)	1	2	3	4
22.	Shows picture(s) of their own or other people's private parts to others.	(0)	1	2	3	4
23.	Asks others to show their private parts or engage in sexual acts while talking **in-person**	(0)	1	2	3	4

ASB-C

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	(0)	1	2	3	4
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).	(0)	1	2	3	4
26.	Coerces others to send sexual pictures or videos. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
27.	Threatens to share sexual pictures or videos of others.	(0)	1	2	3	4
28.	Strokes, massages, or caresses the bodies of others.	(0)	1	2	3	4
29.	Rubs private parts on other people.	(0)	1	2	3	4
30.	Slaps or pokes the buttocks of others.	(0)	1	2	3	4
31.	Touches or tries to touch the private parts of others.	(0)	1	2	3	4
32.	Puts mouth on the breasts or private parts of others.	(0)	1	2	3	4
33.	Inserts or tries to insert objects in ***another child's*** private parts.	(0)	1	2	3	4
34.	Tries to undress others against their will.	(0)	1	2	3	4
35.	Plans to get others to engage in sexual behavior.	(0)	1	2	3	4
36.	Coerces others to engage in sexual behavior. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
37.	Performs sexual behaviors with an animal.	(0)	1	2	3	4
38.	Continues to engage in sexual behavior after being told to stop.	0	1	2	(3)	4

***Please tell us of any other sexual behaviors your child has displayed that were not mentioned above:

_____

***The questions below are to help us better understand the behaviors you described above.
Note: *If you answered "0" (Never) to all the questions above, you do not need to complete the section below.*

A. With whom did your child engage in any of the behaviors above (check all that apply):

- ☒ Children who live in the same home (such as siblings)
- ☐ Children who do not live in the same home (such as cousins)
- ☐ Children at school (such as schoolmates)
- ☐ Children with developmental delays or disabilities
- ☐ Children with another vulnerability (please describe): _____
- ☐ Strangers or people they do not know well
- ☐ Neighbor(s)
- ☐ Adult(s)
- ☐ Children who are younger

B. Where did the behaviors you reported above occur (check all that apply):

- ☒ Home
- ☐ School/preschool/school bus
- ☐ Other (please describe): _____
- ☐ Neighbor's house
- ☐ Childcare provider
- ☐ Public setting (such as stores)
- ☐ Outside (such as a playground)

C. During any of the behaviors you reported above, did your child use coercion, such as force, threats, pressure, bribery, and/or trickery?

- ☒ No
- ☐ Yes (please describe): _____

ASB-C Score Form

Step 1: Critical Items
Check each item below with a non-0 response (i.e., 1, 2, 3, 4).

16. ____	26. ____	34. ____
20. ____	27. ____	35. ____
22. ____	29. ____	36. ____
23. ____	31. ____	37. ____
24. ____	32. ____	38. ✖
25. ____	33. ____	

Step 2: Total Scale Score
Sum all item scores (#1 - #38).

Total Score = 10

Step 3: Total Score Interpretation
Circle the appropriate answer based on the child's age and total scale score

Age Group	*Typical/Expected*	*Concerning*	*Problematic*
3 – 5 years	0 – 10	11	12 – 152
6 – 9 years	0 – 6	(7 – 10)	11 – 152
10 – 12 years	0 – 5	6 – 9	10 – 152

Step 4: Final Interpretation

a. If any critical items are checked in Step 1, the child's behavior is considered *Problematic* and clinical services are likely indicated. (Interpretation of the Total Scale score may be helpful, but is not necessary to classify behavior as "problematic.")

b. In Step 3, a score in the *Concerning* range indicates the child's pattern of behavior is more likely to occur among clinical samples of children with problematic behavior. Further assessment is advised.

c. In Step 3, a score in the *Problematic* range indicates the score is among the highest 5% in the normative population. Clinical services are likely indicated.

Figure 5.4 shows a scored ASB-C for a 9-year-old child. The caregiver reported several concerning behaviors within the "critical items" section, including multiple electronic/online sexual behaviors (#16, #22, #25). There is also evidence that the child attempted to engage others in sexual behaviors (#23, #35) and the caregiver's attempts to correct behaviors have been unsuccessful (#38). The score from the Total Scale further validates the conclusion that the child's behavior is problematic. Examining the different behaviors reported, it appears the child displays a fixation with sexual topics as evidenced by the electronic/online behaviors and making various sexual comments (#7, #10). Although there are indications that the child has attempted to include other children in sexual behaviors, the caregiver has not observed any actual sexual contact with other children. Nonetheless, the supplemental questions at the bottom of the ASB-C suggest the child's behaviors have involved children at school; coordinating with the school to monitor the child's access to electronics and closely supervise behavior when around others may be prudent. Full treatment planning will depend on context, other areas of concern, vulnerabilities, and protective factors; however, directly addressing EOSB, safety planning, and monitoring appears warranted.

Figure 5.5 shows a scored ASB-C of a 10-year-old child (note that this is the same scored ASB-C depicted in the previous chapter as Figure 4.3). The caregiver reports some concerning behaviors on the "critical items" limited to a single attempt to engage another person in sexual behaviors (#23) and the child continuing to engage in sexual behaviors after being told to stop (#38). The Total Scale score of 15 is in the *Problematic* range and suggests the child shows other behaviors beyond the "critical items" identified. Considering the other items endorsed, there appears to be at least some limited exposure to sexual content online (#8, #15) and the child has used sexual language or interpretations on a few occasions (#7, #9, #10). However, all of the

Figure 5.4: Example Interpretation of the ASB-C for a 9-Year-Old

ASB-C

ASB-C

The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the **PAST MONTH** using the scale provided.

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
1.	Stands or sits too close to others.	(0)	1	2	3	4
2.	Hugs people they do not know well.	(0)	1	2	3	4
3.	Kisses people they do not know well.	(0)	1	2	3	4
4.	Touches or tries to touch the breasts of others.	(0)	1	2	3	4
5.	Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	(0)	1	2	3	4
6.	Asks questions about private parts and/or sexual acts to people other than a trusted adult.	(0)	1	2	3	4
7.	Views non-sexual things or topics in a sexual way.	0	1	2	(3)	4
8.	Uses the internet to seek out information on sexual topics.	0	1	2	(3)	4
9.	Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	0	1	2	(3)	4
10.	Uses sexual words in an insulting, disrespectful, and/or suggestive way.	0	1	(2)	3	4
11.	Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	(0)	1	2	3	4
12.	Moves, dances, or makes hand gestures that are sexually suggestive.	(0)	1	2	3	4
13.	Looks at or tries to look at others who are nude, undressing, and/or toileting.	(0)	1	2	3	4
14.	Looks at or tries to look at people engaged in sexual acts.	(0)	1	2	3	4
15.	Looks at pictures or videos that show nudity or sexual acts.	0	1	2	(3)	4
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	0	(1)	2	3	4
17.	Touches or rubs own private parts when ***alone***.	0	(1)	2	3	4
18.	Touches or rubs private parts when around ***other people***.	(0)	1	2	3	4
19.	Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	(0)	1	2	3	4
20.	Inserts or tries to insert objects inside ***own*** private parts.	(0)	1	2	3	4
21.	Shows own private parts to others.	(0)	1	2	3	4
22.	Shows picture(s) of their own or other people's private parts to others.	0	(1)	2	3	4
23.	Asks others to show their private parts or engage in sexual acts while talking **in-person**.	0	(1)	2	3	4

ASB-C

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	(0)	1	2	3	4
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).	0	(1)	2	3	4
26.	Coerces others to send sexual pictures or videos. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
27.	Threatens to share sexual pictures or videos of others.	(0)	1	2	3	4
28.	Strokes, massages, or caresses the bodies of others.	(0)	1	2	3	4
29.	Rubs private parts on other people.	(0)	1	2	3	4
30.	Slaps or pokes the buttocks of others.	0	1	(2)	3	4
31.	Touches or tries to touch the private parts of others.	(0)	1	2	3	4
32.	Puts mouth on the breasts or private parts of others.	(0)	1	2	3	4
33.	Inserts or tries to insert objects in ***another child's*** private parts.	(0)	1	2	3	4
34.	Tries to undress others against their will.	(0)	1	2	3	4
35.	Plans to get others to engage in sexual behavior.	0	(1)	2	3	4
36.	Coerces others to engage in sexual behavior. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
37.	Performs sexual behaviors with an animal.	(0)	1	2	3	4
38.	Continues to engage in sexual behavior after being told to stop.	0	1	2	3	(4)

***Please tell us of any other sexual behaviors your child has displayed that were not mentioned above:

_____

***The questions below are to help us better understand the behaviors you described above.
Note: *If you answered "0" (Never) to all the questions above, you do not need to complete the section below.*

A. With whom did your child engage in any of the behaviors above (check all that apply):

- ☐ Children who live in the same home (such as siblings)
- ☐ Children who do not live in the same home (such as cousins)
- ☒ Children at school (such as schoolmates)
- ☐ Children with developmental delays or disabilities
- ☐ Children with another vulnerability (please describe): _____
- ☐ Strangers or people they do not know well
- ☐ Neighbor(s)
- ☐ Adult(s)
- ☐ Children who are younger

B. Where did the behaviors you reported above occur (check all that apply):

- ☒ Home
- ☒ School/preschool/school bus
- ☐ Other (please describe): _____
- ☐ Neighbor's house
- ☐ Childcare provider
- ☐ Public setting (such as stores)
- ☐ Outside (such as a playground)

C. During any of the behaviors you reported above, did your child use coercion, such as force, threats, pressure, bribery, and/or trickery?

- ☒ No
- ☐ Yes (please describe): _____

ASB-C Score Form

Step 1: Critical Items
Check each item below with a non-0 response (i.e., 1, 2, 3, 4).

16. ✖	26. ____	34. ____
20. ____	27. ____	35. ✖
22. ✖	29. ____	36. ____
23. ✖	31. ____	37. ____
24. ____	32. ____	38. ✖
25. ✖	33. ____	

Step 2: Total Scale Score
Sum all item scores (#1 - #38).

Total Score = 26

Step 3: Total Score Interpretation
Circle the appropriate answer based on the child's age and total scale score

Age Group	*Typical/Expected*	*Concerning*	*Problematic*
3 – 5 years	0 – 10	11	12 – 152
6 – 9 years	0 – 6	7 – 10	(11 – 152)
10 – 12 years	0 – 5	6 – 9	10 – 152

Step 4: Final Interpretation

a. If any critical items are checked in Step 1, the child's behavior is considered *Problematic* and clinical services are likely indicated. (Interpretation of the Total Scale score may be helpful, but is not necessary to classify behavior as "problematic.")

b. In Step 3, a score in the *Concerning* range indicates the child's pattern of behavior is more likely to occur among clinical samples of children with problematic behavior. Further assessment is advised.

c. In Step 3, a score in the *Problematic* range indicates the score is among the highest 5% in the normative population. Clinical services are likely indicated.

identified behaviors have occurred between 2-4 times and it is possible that a number of the endorsed items overlap. In other words, items #7, #9, and #10, for instance, may be related to the same two or three incidents and not each a unique occurrence of sexual behavior. Similarly, items #8 and #15 may be related to the same few attempts to search for sexual information online. The clinician can examine these possibilities by discussing the answers with the caregiver. It is possible that many of the child's behaviors are relatively typical for a 10-year-old (e.g., information-seeking that translated into a few incidents of inappropriate talk), that went beyond acceptable limits during the one incident where the child asked another child to expose their private parts or engage in sexual acts (#23). Thus, interpretation and responses will depend on context, as well as other areas of concern, vulnerabilities, and protective factors.

The last example in Figure 5.6 depicts a 12-year-old child displaying significant and highly concerning PSB. The caregiver provided positive scores for six of the "critical items," and five of them are related to interpersonally intrusive forms of PSB (#23, #31, #34, #35, #36). Most concerning is that some of these behaviors include the use of coercion. Reviewing the questions at the bottom of the ASB-C, the child coerced a sibling by offering to play video games for specific sexual acts. The caregiver reported that multiple children have been impacted by the 12-year-olds' behavior, including children at school and home and at least one child with a developmental delay or disability. The child's Total Scale score is well into the *Problematic* range and an assortment of behaviors, beyond the intrusive and coercive behavior, are reported. The overall picture of the child is that he is quite sexualized, or at least highly interested in sexual topics, and he has included other children in his sexual behavior. Safety planning should be the first priority and preferably occur before the child and caregiver leave the session when this assessment occurred. Comprehensive clinical assessment would be recommended, with

Figure 5.5: Example Interpretation of the ASB-C for a 10-Year-Old

ASB-C

The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the **PAST MONTH** using the scale provided.

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
1.	Stands or sits too close to others.	(0)	1	2	3	4
2.	Hugs people they do not know well.	(0)	1	2	3	4
3.	Kisses people they do not know well.	(0)	1	2	3	4
4.	Touches or tries to touch the breasts of others.	(0)	1	2	3	4
5.	Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	(0)	1	2	3	4
6.	Asks questions about private parts and/or sexual acts to people other than a trusted adult.	(0)	1	2	3	4
7.	Views non-sexual things or topics in a sexual way.	0	1	(2)	3	4
8.	Uses the internet to seek out information on sexual topics.	0	1	(2)	3	4
9.	Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	0	1	(2)	3	4
10.	Uses sexual words in an insulting, disrespectful, and/or suggestive way.	0	1	(2)	3	4
11.	Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	(0)	1	2	3	4
12.	Moves, dances, or makes hand gestures that are sexually suggestive.	(0)	1	2	3	4
13.	Looks at or tries to look at others who are nude, undressing, and/or toileting.	(0)	1	2	3	4
14.	Looks at or tries to look at people engaged in sexual acts.	(0)	1	2	3	4
15.	Looks at pictures or videos that show nudity or sexual acts.	0	1	(2)	3	4
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	(0)	1	2	3	4
17.	Touches or rubs own private parts when ***alone***.	(0)	1	2	3	4
18.	Touches or rubs private parts when around ***other people***.	(0)	1	2	3	4
19.	Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	(0)	1	2	3	4
20.	Inserts or tries to insert objects inside ***own*** private parts.	(0)	1	2	3	4
21.	Shows own private parts to others.	(0)	1	2	3	4
22.	Shows picture(s) of their own or other people's private parts to others.	(0)	1	2	3	4
23.	Asks others to show their private parts or engage in sexual acts while talking **in-person**.	0	(1)	2	3	4

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	(0)	1	2	3	4
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).	(0)	1	2	3	4
26.	Coerces others to send sexual pictures or videos. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
27.	Threatens to share sexual pictures or videos of others.	(0)	1	2	3	4
28.	Strokes, massages, or caresses the bodies of others.	(0)	1	2	3	4
29.	Rubs private parts on other people.	(0)	1	2	3	4
30.	Slaps or pokes the buttocks of others.	0	1	(2)	3	4
31.	Touches or tries to touch the private parts of others.	(0)	1	2	3	4
32.	Puts mouth on the breasts or private parts of others.	(0)	1	2	3	4
33.	Inserts or tries to insert objects in ***another child's*** private parts.	(0)	1	2	3	4
34.	Tries to undress others against their will.	(0)	1	2	3	4
35.	Plans to get others to engage in sexual behavior.	(0)	1	2	3	4
36.	Coerces others to engage in sexual behavior. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
37.	Performs sexual behaviors with an animal.	(0)	1	2	3	4
38.	Continues to engage in sexual behavior after being told to stop.	0	1	(2)	3	4

***Please tell us of any other sexual behaviors your child has displayed that were not mentioned above:

_____

***The questions below are to help us better understand the behaviors you described above.
Note: *If you answered "0" (Never) to all the questions above, you do not need to complete the section below.*

A. With whom did your child engage in any of the behaviors above (check all that apply):

- ☐ Children who live in the same home (such as siblings)
- ☒ Children who do not live in the same home (such as cousins)
- ☒ Children at school (such as schoolmates)
- ☐ Children with developmental delays or disabilities
- ☐ Children with another vulnerability (please describe): _____
- ☐ Strangers or people they do not know well
- ☐ Neighbor(s)
- ☐ Adult(s)
- ☐ Children who are younger

B. Where did the behaviors you reported above occur (check all that apply):

- ☐ Home
- ☒ School/preschool/school bus
- ☐ Other (please describe): _____
- ☒ Neighbor's house
- ☐ Childcare provider
- ☐ Public setting (such as stores)
- ☐ Outside (such as a playground)

C. During any of the behaviors you reported above, did your child use coercion, such as force, threats, pressure, bribery, and/or trickery?

☒ No ☐ Yes (please describe): _____

ASB-C Score Form

Step 1: Critical Items
Check each item below with a non-0 response (i.e., 1, 2, 3, 4).

16. ____	26. ____	34. ____
20. ____	27. ____	35. ____
22. ____	29. ____	36. ____
23. ✖	31. ____	37. ____
24. ____	32. ____	38. ✖
25. ____	33. ____	

Step 2: Total Scale Score
Sum all item scores (#1 - #38).

Total Score = 15

Step 3: Total Score Interpretation
Circle the appropriate answer based on the child's age and total scale score

Age Group	*Typical/Expected*	*Concerning*	*Problematic*
3 – 5 years	0 – 10	11	12 – 152
6 – 9 years	0 – 6	7 – 10	11 – 152
10 – 12 years	0 – 5	6 – 9	(10 – 152)

Step 4: Final Interpretation

a. If any critical items are checked in Step 1, the child's behavior is considered *Problematic* and clinical services are likely indicated. (Interpretation of the Total Scale score may be helpful, but is not necessary to classify behavior as "problematic.")

b. In Step 3, a score in the *Concerning* range indicates the child's pattern of behavior is more likely to occur among clinical samples of children with problematic behavior. Further assessment is advised.

c. In Step 3, a score in the *Problematic* range indicates the score is among the highest 5% in the normative population. Clinical services are likely indicated.

Figure 5.6: Example Interpretation of the ASB-C for a 10-Year-Old

ASB-C

ASB-C

The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the **PAST MONTH** using the scale provided.

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
1.	Stands or sits too close to others.	(0)	1	2	3	4
2.	Hugs people they do not know well.	(0)	1	2	3	4
3.	Kisses people they do not know well.	(0)	1	2	3	4
4.	Touches or tries to touch the breasts of others.	(0)	1	2	3	4
5.	Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	(0)	1	2	3	4
6.	Asks questions about private parts and/or sexual acts to people other than a trusted adult.	(0)	1	2	3	4
7.	Views non-sexual things or topics in a sexual way.	0	1	2	(3)	4
8.	Uses the internet to seek out information on sexual topics.	0	1	2	(3)	4
9.	Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	0	1	2	3	(4)
10.	Uses sexual words in an insulting, disrespectful, and/or suggestive way.	0	1	2	(3)	4
11.	Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	(0)	1	2	3	4
12.	Moves, dances, or makes hand gestures that are sexually suggestive.	0	(1)	2	3	4
13.	Looks at or tries to look at others who are nude, undressing, and/or toileting.	(0)	1	2	3	4
14.	Looks at or tries to look at people engaged in sexual acts.	(0)	1	2	3	4
15.	Looks at pictures or videos that show nudity or sexual acts.	0	1	2	(3)	4
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	(0)	1	2	3	4
17.	Touches or rubs own private parts when ***alone***.	(0)	1	2	3	4
18.	Touches or rubs private parts when around ***other people***.	0	1	(2)	3	4
19.	Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	(0)	1	2	3	4
20.	Inserts or tries to insert objects inside ***own*** private parts.	(0)	1	2	3	4
21.	Shows own private parts to others.	0	1	(2)	3	4
22.	Shows picture(s) of their own or other people's private parts to others.	(0)	1	2	3	4
23.	Asks others to show their private parts or engage in sexual acts while talking ***in-person***.	0	1	(2)	3	4

ASB-C

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	(0)	1	2	3	4
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).	(0)	1	2	3	4
26.	Coerces others to send sexual pictures or videos. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	(0)	1	2	3	4
27.	Threatens to share sexual pictures or videos of others.	(0)	1	2	3	4
28.	Strokes, massages, or caresses the bodies of others.	0	(1)	2	3	4
29.	Rubs private parts on other people.	(0)	1	2	3	4
30.	Slaps or pokes the buttocks of others.	0	1	2	(3)	4
31.	Touches or tries to touch the private parts of others.	0	1	(2)	3	4
32.	Puts mouth on the breasts or private parts of others.	(0)	1	2	3	4
33.	Inserts or tries to insert objects in ***another child's*** private parts.	(0)	1	2	3	4
34.	Tries to undress others against their will.	0	(1)	2	3	4
35.	Plans to get others to engage in sexual behavior.	0	1	(2)	3	4
36.	Coerces others to engage in sexual behavior. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	0	(1)	2	3	4
37.	Performs sexual behaviors with an animal.	(0)	1	2	3	4
38.	Continues to engage in sexual behavior after being told to stop.	0	1	2	3	(4)

***Please tell us of any other sexual behaviors your child has displayed that were not mentioned above:

_____

***The questions below are to help us better understand the behaviors you described above.
Note: *If you answered "0" (Never) to all the questions above, you do not need to complete the section below.*

A. With whom did your child engage in any of the behaviors above (check all that apply):

- ☒ Children who live in the same home (such as siblings)
- ☐ Children who do not live in the same home (such as cousins)
- ☒ Children at school (such as schoolmates)
- ☒ Children with developmental delays or disabilities
- ☐ Children with another vulnerability (please describe): _____
- ☐ Strangers or people they do not know well
- ☐ Neighbor(s)
- ☐ Adult(s)
- ☐ Children who are younger

B. Where did the behaviors you reported above occur (check all that apply):

- ☒ Home
- ☒ School/preschool/school bus
- ☐ Other (please describe): _____
- ☐ Neighbor's house
- ☐ Childcare provider
- ☐ Public setting (such as stores)
- ☒ Outside (such as a playground)

C. During any of the behaviors you reported above, did your child use coercion, such as force, threats, pressure, bribery, and/or trickery?

- ☐ No
- ☒ Yes (please describe): Told his brother he could play video games if he sucked his penis.

ASB-C Score Form

Step 1: Critical Items
Check each item below with a non-0 response (i.e., 1, 2, 3, 4).

16. ____	26. ____	34. ✖
20. ____	27. ____	35. ✖
22. ____	29. ____	36. ✖
23. ✖	31. ✖	37. ____
24. ____	32. ____	38. ✖
25. ____	33. ____	

Step 2: Total Scale Score
Sum all item scores (#1 - #38).

Total Score = 37

Step 3: Total Score Interpretation
Circle the appropriate answer based on the child's age and total scale score

Age Group	*Typical/Expected*	*Concerning*	*Problematic*
3 – 5 years	0 – 10	11	12 – 152
6 – 9 years	0 – 6	7 – 10	11 – 152
10 – 12 years	0 – 5	6 – 9	(10 – 152)

Step 4: Final Interpretation

a. If any critical items are checked in Step 1, the child's behavior is considered *Problematic* and clinical services are likely indicated. (Interpretation of the Total Scale score may be helpful, but is not necessary to classify behavior as "problematic.")

b. In Step 3, a score in the *Concerning* range indicates the child's pattern of behavior is more likely to occur among clinical samples of children with problematic behavior. Further assessment is advised.

c. In Step 3, a score in the *Problematic* range indicates the score is among the highest 5% in the normative population. Clinical services are likely indicated.

treatment planning depending on context, other areas of concern, vulnerabilities, and protective factors.

Clinical Uses of the ASB-C

Identifying PSB. The general recommendation is that any case where a "critical item" is endorsed and/or where the profile's Total Scale score falls in the *Problematic* range be identified as "problematic" and the child considered a likely candidate for further assessment and potential clinical intervention. Although exceptions to this rule are likely, application of this recommendation should effectively identify the vast majority of cases where PSB is present and clinical services are warranted.

Safety Planning. Any endorsement of a "critical item" signifies a need for a safety plan to prevent the reoccurrence of these behaviors. Remembering that these behaviors represent highly unusual behavior for children and the likelihood that harm may occur to the child or another person or animal, it is advised that safety planning occur before the child/caregiver leave the assessment session. Various treatment programs discuss safety planning in depth and clinicians are encouraged to be aware of appropriate safety procedures before beginning work with children exhibiting PSB (e.g., Allen, in press; https://connect.ncsby.org/psbcbt).

Treatment Tool. The ASB-C can be used to facilitate a conversation with a caregiver about the child's behavior. For instance, a clinician may ask a caregiver to describe the setting(s) where behaviors are most likely to occur, how the caregiver responds to the problematic behaviors, and if the frequency fluctuates across settings or caregivers. Such discussions can yield important information for safety and treatment planning purposes.

Assessment of Sexual Abuse. As discussed previously, sexual abuse is a commonly identified risk factor for PSB, but many children with PSB do not have a history of sexual abuse. As such, it may be helpful for assessments with children who experienced maltreatment to include a measure of sexualized behavior, such as the ASB-C. This is designed for clinical decision making and the results of the ASB-C measure should not be used in an attempt investigate or "figure out" whether a traumatic event, including sexual abuse, has occurred. The ASB-C will not indicate if the child has been exposed to sexual abuse.

Research Uses of the ASB-C

Assessment of PSB. Research studies of PSB tend to utilize either a dichotomous present or absent classification or a continuous score of PSB. Using the scoring instructions above, the ASB-C lends itself to both methods of assessment. In addition, much prior work on PSB is focused specifically on interpersonally intrusive forms of behavior. The ASB-C includes several of these items that can be isolated to create a separate "intrusive PSB" subscale, depending on the objectives of the research. Several items also examine electronic/online sexual behaviors, which could constitute a separate scale, depending on researcher preferences.

Epidemiological Research. The normative sample obtained in the development of the ASB-C was representative of the U.S. population and the method of data collection suggests that the ASB-C is appropriate for epidemiological research. The prevalence and incidence of PSB in the general population is unknown and more sophisticated epidemiological methods are required to determine these estimates. The development of the ASB-C helps make this research feasible.

Cross-cultural Comparisons. To date, limited research has incorporated a cultural lens to better understand childhood sexual behavior and PSB. The development of the ASB-C

encourages studies examining differences and similarities of childhood sexual behavior across cultures. Such research can inform our understanding of sexual development and improve clinical service delivery in disparate countries and settings.

Clinical and Developmental Research. Research on the sexual development of children is often viewed as difficult for various reasons. The acceptability and availability of the ASB-C offer developmental researchers the opportunity to integrate a measure of sexual behavior into studies in hopes of advancing knowledge on typical and problematic development. Similarly, the advent of the ASB-C represents a significant improvement in measurement that may enhance the methodological quality of research on the etiology and treatment of PSB.

CHAPTER 6:
The ASB-C Extended Version

Previous measures of child sexual behavior and PSB typically asked respondents to report on the frequency of behavior over the prior six months. This timeframe aligned these prior tools with other measures of childhood emotional and behavioral concerns, such as the CBCL, which also asked about the prior six months. Although the ASB-C development team believes that such a timeframe inhibits the ability to track clinical change and may result in giving the mistaken impression that more distant behaviors are occurring in the present time, it was recognized that the six-month period holds certain advantages. For instance, a one-month period may not capture behaviors that were recently identified but occurred more than one month ago. This is problematic given long wait times to access services. In addition, the six-month timeframe may be advantageous for epidemiological purposes when attempting to document the prevalence of different behaviors, including PSB. A longer time period also provides a more comprehensive developmental "snapshot," and yields more longitudinal information regarding the occurrence of behaviors. With this mind, the team developed the ***Assessment of Sexual Behavior-Child Extended version*** (ASB-CE) alongside the standard ASB-C to provide a longer assessment frame.

Development and Administration of the ASB-CE

The ASB-CE takes the standard ASB-C and adds an additional two columns designed to ascertain the occurrence of the behaviors over the past six months, using a simple "No" or "Yes" format. Caregivers are asked to answer each question twice, reporting on the frequency of the

behaviors over the past month (standard ASB-C) and then for the past six months. When presenting the ASB-CE to respondents, it is beneficial to explain the structure of the measure to ensure understanding and appropriate completion. The instructions are printed at the top of each time period, and a heavy black line separates the "Past Month" column from the "Six (6) Months" column. At the bottom of the measure, the ancillary information from the standard ASB-C is included, but the directions are modified to state that the caregiver should not complete the section if they answered "0" (Never) and "No" to each of the 38 items. The ASB-CE was tested alongside the standard ASB-C during the final psychometric evaluation.

Scoring and Interpretation of the ASB-CE

The ASB-CE was tested in the two normative samples and these data were used to derive certain psychometric characteristics (see *Chapter 7: Psychometric Properties and Standardization*). Although results suggested strong psychometric qualities for the "6 Months" response section included within the ASB-CE, the clinical sample was not administered this extended version and it is unclear how well responses on the "6 Months" portion of the ASB-CE discriminate normative from clinical samples. As such, insufficient data is available to recommend any particular format of scoring or interpreting the "6 Months" responses of ASB-CE. It is recommended that the ASB-CE be used to collect a more extensive history of the child's sexual behaviors for information gathering purposes, but that identification of problematic behavior rely on the "Past Month" format as discussed in *Chapter 5: Interpretation and Uses of the ASB-C*. As before, examining item-level data from the ASB-CE may be helpful for clinical purposes and should be considered by a clinician.

Chapter 7
Psychometric Properties and Standardization

Validation of the ASB-C was a multi-step process designed to determine if the measure demonstrated satisfactory levels of various psychometric properties. This included multiple forms of validity and reliability. This process was also necessary to obtain normative data that could be used for determining when a particular frequency and/or diversity of behaviors might be considered problematic. The data reported here were collected in the United States and may not be applicable in other countries or cultures that have different norms regarding sexual behavior, particularly among children. For the interested reader, statistical analyses were published in Allen et al. (2026).

Samples

To sufficiently test the psychometric qualities of the measure, data were collected from several different samples. Each of these samples are described below and the demographic information for each sample is included in a table format in Appendix A.

Normative Sample. The ASB-C and ASB-CE were tested in a normative sample of 1,400 caregivers of children between the ages of 3 and 12 years. The team contracted with the survey research firm YouGov to collect the data from within their predefined pool of over one million potential respondents. YouGov attempted to recruit a sample that was representative of the national population and derived weights for use in statistical analyses that corrected for variations of the obtained sample from national demographic characteristics. Caregivers within this sample completed the ASB-C, the ASB-CE, the SDQ, the CATS, and a comprehensive

demographic questionnaire. All measures were completed in a single time period and no follow-up was available. Participants were compensated by YouGov through their standard participant incentive program. This sample was used for principal components analyses (PCA), to derive estimates of internal reliability, examinations of convergent and discriminant validity, construction of normative tables, and to ascertain relationships with demographic characteristics.

Pennsylvania (PA) Sample. A total of 7,000 caregivers of children between the ages of 3 and 12 years across the Commonwealth of Pennsylvania received an invitation letter to complete an online survey. These caregivers were identified through a contracted mail service, and postal codes associated with lower socioeconomic strata were oversampled to increase the socioeconomic and racial/ethnic diversity of the sample. The questionnaire included the ASB-C, the ASB-CE, the CSBI, and a measure of social modeling of sexuality that may occur in the home (i.e., a modified version of the Family Sexuality Index [FSI; Friedrich, 2007]). At the end of the survey, caregivers were asked if they would complete a second, shorter questionnaire a week later, if contacted. Those that consented received an email invitation to complete a second survey, which included only the ASB-C and the ASB-CE. The resulting sample of 271 caregivers was used to examine test-retest reliability, conduct confirmatory factor analyses (CFA), and evaluate convergent validity of the ASB-C with the CSBI. Caregivers received a $15 electronic gift-card for completing the first survey and a $10 electronic gift card for completing the second survey.

Clinical Sample. To establish criterion validity, which is to say that the ASB-C can effectively identify children actively displaying PSB, it was necessary to identify a clinical sample of children being treated specifically for PSB. Members of the development team are actively engaged in supervising and providing clinical services for children with PSB and

provide training to clinicians in the delivery of treatment services for children with PSB. The ASB-C was implemented within the clinics of some members of the team and provided to trainees attending training programs for use with their own PSB treatment cases. These data were reported to and compiled by the team to yield a composite clinical sample. Because these data were collected within the confines of community-based clinical practice, the procedures available for data collection varied. Nonetheless, a pre-treatment report on the ASB-C was required for inclusion. A total of 110 clinical cases were included in the analyses.

Factor Structure

Principal Components Analyses. The Normative sample was used to perform principal components analyses (PCA). Of the available cases (n = 1,400), 623 cases provided "0" responses for every item on the ASB-C. As such, these cases provided no variability and were removed from the sample prior to computing the PCA. The removed portion of the sample did not differ from the retained portion of the sample (n = 791) on child gender (X^2 = 3.68, p = .298), child race (X^2 = 4.43, p = .619), caregiver relationship to child (X^2 = 6.21, p = .286), caregiver gender (X^2 = 2.07, p = .151), caregiver race (X^2 = 8.87, p = .261), caregiver education (X^2 = 9.34, p = .096), caregiver marital status (X^2 = 5.52, p = .356), caregiver employment status (X^2 = 5.92, p = .657), or family income (X^2 = 16.02, p = .452). However, the removed subsample was slightly older (M age = 8.23, SD = 2.80) than the retained subsample (M age = 7.44, SD = 2.90; t = 5.20, p < .001). Given that younger children tend to display higher frequencies of normative and problematic sexual behavior, this was not surprising. In addition, normality checks showed that all items displayed significant positive skew, as might be expected, and all items were log-transformed prior to running analyses.

Initial PCA employing varimax rotation and using the retained subsample demonstrated significant problems with the structure of the measure. Several items appeared to cluster together and accounted for significant variance, thereby preventing additional factors from being identified. Upon inspection, it was found that all of these items are generally considered severe and occurred with extremely low frequencies (i.e., any non-"0" response) within the normative sample as a whole (≤1.0%). In consultation with a statistician, it was decided to remove these items from the analysis and re-compute the PCA. Given the extremely low base rate of these behaviors in the normative sample, the team concluded that these behaviors should constitute "critical items" where a single occurrence is sufficient to identify a PSB. These items, and the frequency with which they occurred in the normative sample (n = 1,400), are listed in Table 7.1.

After removing these low base rate items, the PCA with varimax rotation yielded more useful results. The scree plot suggested a two- or three-factor solution best fit the data. Across both solutions, the first two factors were remarkably similar in terms of the items that loaded on those factors. The third factor in the three-factor solution included only three items and primarily constituted non-sexual boundary violations (e.g., "Stands or sits too close to others," "Hugs people they do not know well," "Kisses people they do not know well") and internal consistency of this third factor was very weak (Cronbach's α = .36). Given these considerations, the decision was made to retain the two-factor solution, which is provided in Table 7.2 below. Items were retained based on the statistical strength of the factor loading (≥ .40; Stevens, 1992; Tabachnick & Fidell, 2007), followed by a clear clinical and/or theoretical rationale for including an item in the measure. As a result, Factor 1 included 8 items (18, 17, 13, 9, 21, 19, 4, 30) and Factor 2 included 8 items (15, 8, 7, 11, 14, 10, 6, 12).

Table 7.1: Items with an Extremely Low Base Rate (≤ 1.0%) in the Normative Sample

Item	*f (%)*
16. Looks at picture or videos of violent, aggressive, and/or extreme sex acts.	14 (1.0)
20. Inserts or tries to insert objects inside ***own*** private parts.	7 (0.5)
22. Shows picture(s) of their own or other people's private parts to others.	7 (0.5)
23. Asks others to show their private parts or engage in sexual acts while talking ***in-person***.	11 (0.8)
24. Sends sexual messages, pictures, and/or videos to others (such as through **e**mail, texts, social media).	3 (0.2)
25. Uses digital media (such as email, texts, social media) to ask others to send them pictures or videos showing nudity or sexual acts.	6 (0.4)
26. Coerces others to send sexual pictures or videos in a digital format.	5 (0.4)
27. Threatens to share sexual pictures or videos of others.	2 (0.2)
28. Strokes, massages, and/or caresses the bodies of others.	13 (1.0)
29. Rubs private parts on other people.	10 (0.7)
31. Touches or tries to touch the private parts of others.	13 (1.0)
32. Puts mouth on the breasts or private parts of others.	8 (0.6)
33. Inserts or tries to insert objects in ***another child's*** private parts.	4 (0.3)
34. Tries to undress others against their will.	8 (0.6)
35. Plans to get others to engage in sexual behavior.	3 (0.2)
36. Coerces others to engage in sexual behavior.	3 (0.2)
37. Performs sexual behaviors with an animal.	10 (0.8)
38. Continues to engage in sexual behavior after being told to stop.	11 (0.8)

Note: n = 1,400

Table 7.2: Factor Loadings for the Two-Factor Solution

Item	F1	F2
18. Touches or rubs private parts when around ***other people***.	**.72**	-.07
17. Touches or rubs own private parts when ***alone***.	**.62**	.07
13. Looks at or tries to look at others who are nude, undressing, and/or toileting.	**.57**	.13
9. Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	**.53**	.19
21. Shows own private parts to others.	**.51**	.19
19. Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	**.49**	.16
4. Touches or tries to the touch the breasts of others.	**.46**	.24
30. Slaps or pokes the buttocks of others.	**.40**	.09
5. Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	.35	.23
1. Stands or sits too close to others.	.27	-.07
2. Hugs people they do not know well.	.18	.04
15. Looks at pictures or videos that show nudity or sexual acts.	-.01	**.67**
8. Uses the internet to seek out information on sexual topics.	-.08	**.62**
7. Views non-sexual things or topics in a sexual way.	.10	**.60**
11. Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	.14	**.57**
14. Looks at or tries to look at people engaged in sexual acts.	.21	**.55**
10. Uses sexual words in an insulting, disrespectful, and/or suggestive way.	.04	**.49**
6. Asks questions about private parts and/or sexual acts to people other than a trusted adult.	.15	**.43**
12. Moves, dances, or makes hand gestures that are sexually suggestive.	.22	**.43**
3. Kisses people they do not know well.	.26	.35

Confirmatory Factor Analyses. Confirmatory factor analyses (CFA) were conducted by applying the obtained two-factor solution to the data collected from the PA sample (n = 271). Initial CFA showed that the model performed relatively poorly, (X^2 = 393.24, df = 103, p < .001; RMSEA = .10; CFI = .77; TLI = .73; SRMR = .08). Modification indices provided a number of useful suggestions that required only minor changes to the model, including allowing several

items within a given factor to correlate together. Allowing this type of within-factor association is a commonly employed statistical technique and considerably improved the fit of the model. The final model was either an "acceptable" or "good" fit according to three of the examined indices (X^2 = 268.88, df = 95, $p < .001$; RMSEA = .08; SRMR = .07) and a marginal fit according to two of the indices (CFI = .86; TFI = .83).

Factor 1 includes 8 items assessing self-focused, looking, and showing behaviors that clinical experience suggests are relatively more common among preschool-aged children. Indeed, the summation of these items showed that higher scores were associated with younger ages in both the normative (r = -.12, $p < .001$) and PA samples (r = -.25, $p < .001$). This factor was therefore renamed the ***Early Development*** subscale. Factor 2 comprises 8 items that largely suggest a level of interest in or desire for knowledge about sex, including information seeking, looking behaviors, and inappropriate conversations or physical gestures. It might be expected that these behaviors occur with greater frequency among children in the pre-adolescent stage as they become more aware of mature sexual behaviors and topics through peers, school, the home, and their own physical development. The sum of the scores on this factor was positively correlated with the child's age in the Normative (r = .22, $p < .001$) and PA samples (r = .28, $p < .001$), and the factor was labeled the ***Sexual Interest*** subscale (See Table 7.2).

Reliability

Internal Consistency. The ASB-C includes three scales, the *Early Development* and *Sexual Interest* subscales as discussed above, and the summation of all 38 items of the scale, termed the *Total* scale. Internal consistency was calculated within each of the three subsamples using Cronbach's alpha and, as seen in Table 7.3, estimates ranged from acceptable to good.

Table 7.3: Internal Consistency of the ASB-C Scales Across Three Samples

Scale	Normative (*n* = 1,400)	PA (*n* = 271)	Clinical (*n* = 110)
Total Scale-all items	.84	.81	.85
Early Development Subscale	.72	.79	.70
Sexual Interest Subscale	.68	.74	.75

Test-retest Reliability. Test-retest reliability was evaluated using the PA sample only. Of the 271 initial respondents, 163 agreed to and completed a second administration of the ASB-C. Participants who completed the second wave of data collection did so after an average of 8.39 days (*SD* = 2.24, Range = 7 – 26). Significant and strong correlations between the two administrations were observed for the *Total* scale ($r = .90$, $p < .001$), and both the *Early Development* ($r = .89$, $p < .001$) and *Sexual Interest* ($r = .87$, $p < .001$) subscales.

Inter-rater Reliability/Gender of Caregiver. Inter-rater reliability could not be determined as none of the samples included administration of the ASB-C to two different caregivers. However, early studies of PSB placed an emphasis on having female caregivers, typically mothers, complete the measure of sexual behavior. In the normative sample, the gender of the caregiver did not affect the scores provided for the *Total* scale ($t = .44$, $p = .661$) or the *Sexual Interest* subscale ($t = 1.75$, $p = .08$); however, female caregivers tended to provide higher scores than their male counterparts on the *Early Development* subscale, though the effect was small ($t = 2.33$, $p = .02$, $d = .13$). Within the PA sample, there were no differences on any of the scales based on the gender of the reporter: *Total* ($t = .94$, $p = .349$), *Early Development* ($t = 1.37$, $p = .173$), *Sexual Interest* ($t = .44$, $p = .661$).

Validity

Concurrent Validity. Concurrent validity was evaluated in two ways. First, within the PA sample, 247 caregivers from the original sample successfully completed the ASB-C and the CSBI. Although outdated, the CSBI is the best available option for an alternative measure of child sexual behavior. Despite the differences in the definitions of PSB utilized in constructing each measure and in the content included (see Chapter 1), it was hypothesized that the two measures would significantly correlate. As expected, results showed that the CSBI Total scale was strongly correlated with the ASB-C *Total* scale ($r = .81$, $p < .001$) as well as the *Early Development* ($r = .73$, $p < .001$) and *Sexual Interest* ($r = .59$, $p < .001$) subscales.

Second, concurrent validity was assessed by comparing results from the Normative and PA samples to the Clinical sample. Given that the Clinical sample was entirely comprised of children receiving treatment for PSB, evidence of validity would be demonstrated by results showing that the Clinical sample scored higher on the ASB-C scales than the Normative and PA samples. An ANOVA revealed significant between group differences on the *Total* scale ($F = 317.37$, $p < .001$, $\eta^2 = .26$) and post hoc analyses showed that this was attributable to the Clinical group ($M = 18.31$, $SD = 13.16$) scoring significantly higher than the Normative ($M = 2.68$, $SD = 5.40$; Tukey HSD $p < .001$, Scheffe $p < .001$) and PA samples ($M = 5.37$, $SD = 6.58$; Tukey HSD $p < .001$, Scheffe $p < .001$). Similar results were found with the *Early Development* and *Sexual Interest* subscales.

Convergent Validity. Meta-analytic results suggest that PSB is positively correlated with internalizing problems (e.g., depression, anxiety), externalizing problems (e.g., defiance, aggression), and exposure to modeling of sexual behavior (see Chapter 1). To test the convergent validity of the ASB-C, scores were correlated with each of these three constructs. In the

normative sample, the SDQ was administered to allow for assessment of internalizing symptoms (SDQ-Emotional Problems subscale) and externalizing symptoms (SDQ-Conduct Problems subscale). As expected, significant correlations were observed between all scales of the ASB-C and SDQ (see Table 7.4). However, the strengths of the correlations were significantly weaker than when the ASB-C was compared to the CSBI, suggesting the ASB-C is more likely assessing sexual behavior than general emotional and/or behavioral concerns.

Table 7.4: Correlations of the ASB-C with Convergent and Discriminant Variables

Scale	1	2	3	4	5	6
1. ASB-C Total Scale	-					
2. ASB-C Early Development subscale	.83*	-				
3. ASB-C Sexual Interest subscale	.72*	.43*	-			
4. SDQ-Emotional Problems subscale	.28*	.23*	.25*	-		
5. SDQ-Conduct Problems subscale	.25*	.21*	.17*	.41*	-	
6. SDQ-Prosocial Behavior subscale	.02	.04	<.01	-.01	-40*	-

*$p < .01$; SDQ = Strengths and Difficulties Questionnaire

In the PA sample, the Family Sexuality Index (FSI) was administered to examine the relationship of the ASB-C with a form of social modeling of sexual behavior ($n = 247$). As hypothesized, all scales of the ASB-C correlated with the FSI. The strongest correlations were found with the *Total* scale ($r = .34$, $p < .001$) and *Early Development* subscale ($r = .32$, $p < .001$). The association between the FSI and the *Sexual Interest* subscale was weaker, though still significant ($r = .15$, $p = .018$).

Discriminant Validity. Given that PSB is linked with a variety of emotional, behavioral, and social concerns, relatively few clinical constructs are available for the purposes of testing discriminant validity. But, there is no known association of PSB with prosocial behavior. As such, to test discriminant validity of the ASB-C, a correlation was computed for the Prosocial

Behavior subscale of the SDQ with the ASB-C. As shown in Table 7.4, the ASB-C was not related to the child's prosocial behavior, or lack thereof (r = .02, p = 365).

Demographic Analyses

A key question in determining the validity of the ASB-C is whether it operates similarly across different demographic groups, and this was tested in a series of analyses using the three independent samples discussed previously. Complete descriptive and statistical information for all of the following analyses are provided in Appendix A.

Child Gender. Within the normative sample, child gender was not related to scores on the *Total* scale (t = .46, p = .643) or *Sexual Interest* subscale (t = 1.56, p = .12); however, girls (M = .77, SD = 2.25) received a lower score than boys (M = 1.08, SD = 2.30) on the *Early Development* subscale (t = 2.48, p = .013, d = .13). These results were replicated with the PA sample, with girls (M = 1.97, SD = 3.46) scoring lower than boys (M = 2.94, SD = 4.10) on the *Early Development* subscale (t = 2.08, p = .039, d = .26), while no gender differences were apparent on the *Total* scale (t = 1.22, p = .223) or *Sexual Interest* subscale (t = .69, p = .493). Similarly, there were no gender differences noted when examining data from the Clinical group: *Total* (t = .75, p = .455), *Early Development* (t = .71, p = .477), *Sexual Interest* (t = .62, p = .54).

Child Race and Ethnicity. With regards to race and ethnicity, caregivers in the normative sample were provided with several response options. Nonetheless, relatively small frequencies of participants identifying with certain ethnic groups precluded the use of all possible categories within analyses. The race and ethnicity responses were consolidated into the classifications displayed in Appendix A. Within the normative sample, a one-way ANOVA with four levels (i.e., White, Black, Hispanic/Latino, "Other") yielded significant results for all three

of the ASB-C scales: *Total* ($F = 7.15$, $p < .001$, $\eta^2 = .02$), *Early Development* ($F = 9.98$, $p < .001$, $\eta^2 = .02$), *Sexual Interest* ($F = 4.44$, $p = .004$, $\eta^2 = .01$). Post hoc Bonferroni analyses showed that the variability on the *Total* scale was primarily due to White children having higher scores ($M = 2.95$, $SD = 5.96$) than Hispanic/Latino children ($M = 1.29$, $SD = 2.26$; $p < .001$); the same pattern was found for scores on the *Sexual Interest* subscale (White: $M = .49$, $SD = 1.64$; Hispanic/Latino: $M = .21$, $SD = .76$; $p = .02$). On the *Early Development* subscale, White children also scored higher ($M = 1.14$, $SD = 2.52$) than Black children ($M = .53$, $SD = 1.63$; $p = .017$) and Hispanic/Latino children ($M = .36$, $SD = .97$; $p < .001$). There was also significant variability on this subscale between Hispanic/Latino children and those classified in the "Other" category ($M = 1.11$, $SD = 2.76$; $p = .005$).

Interestingly, the same analyses using the PA sample revealed no differences across racial/ethnic groups: *Total* ($F = .96$, $p = .414$, $\eta^2 = .01$), *Early Development* ($F = 2.18$, $p = .09$, $\eta^2 = .02$), *Sexual Interest* ($F = 1.08$, $p = .359$, $\eta^2 = .01$). The effect sizes across these two samples were functionally equivalent; the small size of the effect resulted in significant findings in the larger normative sample and non-significant results in the smaller PA sample. Although no group differences were observed in the Clinical group for *Total* scale ($F = 2.16$, $p = .097$), differences did emerge when examining the subscales (*Early Development*: $F = 2.81$, $p = .043$; *Sexual Interest*: $F = 3.26$, $p = .024$). However, looking across post hoc group comparisons using both the Tukey and Scheffe tests, the only significant contrast was for the *Early Development* subscale where Latino/Hispanic children received lower scores ($M = 5.16$, $SD = 5.68$) than African-American children ($M = 10.67$, $SD = 5.38$).

Caregiver Race and Ethnicity. Caregiver race and ethnicity was re-coded using the same method described above for children. Similar to child race and ethnicity, differences were

noted for all three of the ASB-C scales in the normative sample: *Total* ($F = 6.32$, $p < .001$, $\eta^2 = .01$), *Early Development* ($F = 10.25$, $p < .001$, $\eta^2 = .02$), *Sexual Interest* ($F = 3.43$, $p = .016$, $\eta^2 = .01$). Similarly, the same pattern of post hoc results observed with child race and ethnicity emerged when examining caregiver race and ethnicity, with White caregivers reporting higher scores than Hispanic/Latino caregivers on the *Total* (White: $M = 2.94$, $SD = 5.91$; Hispanic/Latino: $M = 1.39$, $SD = 1.39$; $p < .001$) and *Early Development* scales (White: $M = 1.15$, $SD = 2.49$; Hispanic/Latino: $M = .38$, $SD = 1.20$; $p < .001$). White caregivers also reported higher scores on the *Early Development* subscale than Black caregivers ($M = .45$, $SD = 1.35$; $p = .003$). Caregivers within the "Other" category ($M = .92$, $SD = 2.90$) endorsed higher scores on the *Early Development* subscale than Hispanic/Latino caregivers ($p = .018$). Also, as before, these findings were not replicated in the PA sample: *Total* ($F = .50$, $p = .682$, $\eta^2 = .01$), *Early Development* ($F = 2.05$, $p = .107$, $\eta^2 = .02$), *Sexual Interest* ($F = 1.09$, $p = .353$, $\eta^2 = .01$).

Caregiver Relationship to Child. Caregiver relationship to child was re-coded as either a biological parent or a "surrogate" caregiver, which collectively included grandparents, other kin relationships, step-parents, foster parents, and adoptive parents. Within the normative sample, biological parents ($n = 1{,}315$) reported lower scores on the *Total* scale ($M = 2.44$, $SD = 5.15$) than surrogate caregivers ($n = 80$; $M = 3.84$, $SD = 4.98$; $t = 2.38$, $p = .017$, $d = .27$), although the groups had similar scores on the *Early Development* ($t = 1.42$, $p = .157$) and *Sexual Interest* subscales ($t = 1.84$, $p = .069$). For the PA sample, caregiver relationship to the child was unrelated to scores: *Total* ($t = 1.13$, $p = .275$), *Early Development* ($t = .34$, $p = .734$), *Sexual Interest* ($t = 1.02$, $p = .322$).

Household Annual Income. Reported household income was stratified into five categories based on annual earnings: Less than $30,000, $30,000-$60,000, $60,000-$90,000,

$90,000-$120,000, and more than $120,000. One-way ANOVAs with the normative sample showed significant variability for the *Total* ($F = 3.03$, $p = .017$, $\eta^2 = .01$) and *Early Development* scales ($F = 4.68$, $p < .001$, $\eta^2 = .01$), but not for the *Sexual Interest* scale ($F = 2.77$, $p = .221$). However, the only significant post hoc comparison was found on the *Total* scale with caregivers earning between $30,000 and $60,000 ($M = 1.95$, $SD = 3.62$) reporting lower scores than caregivers earning more than $120,000 ($M = 3.19$, $SD = 6.42$; $p = .03$). These results were not replicated with the PA sample: *Total* ($F = 1.57$, $p = .184$), *Early Development* ($F = 2.23$, $p = .067$), *Sexual Interest* ($F = .41$, $p = .80$).

Standardization and Clinical Utility of the ASB-C

The ASB-C was standardized using the Normative sample. Age was negatively correlated with score on the *Total* scale in all three samples (Normative: $r = -.08$, $p = .002$; PA: $r = -.16$, $p = .008$; Clinical: -.19, $p = .049$). This resulted in the decision to standardize the scores separately for three age groups: Preschool (ages 3-5), School-Age (ages 6-9) and Pre-teen (ages 10-12). Given that child gender did not relate to scores on the *Total* scale, separate gender norms were deemed unnecessary. In light of the highly skewed nature of the data, it was decided not to utilize a form of metric that necessitated the imposition of a normative distribution, such as T-scores or standard scores. Rather, percentages were employed to describe the data across the three samples (see Appendix D).

To statistically examine the point at which scores on the ASB-C *Total* scale distinguished between the Normative and Clinical samples, receiver operating characteristic (ROC) curves were computed. These analyses provided clear results (AUC = .93, $p < .001$, 95% CI = .91 - .95) with a cutoff score of 5.5 (i.e., 6 and above) yielding optimal sensitivity (.84) and specificity (.85). Indeed, only 15.2% of the Normative sample exceeded this mark, while 83.6% of the

Clinical sample did so. Given the previously noted correlation of age with the *Total* scale score, separate analyses were computed for each of the three age ranges mentioned previously. The optimal cutoff score for preschoolers was significantly higher when comparing the Normative and Clinical samples, at 11.5 (i.e., 12 and above), reflecting the common finding that younger children more commonly display sexualized behaviors (AUC = .94, $p < .001$, 95% CI = .89 - .99). Sensitivity (.86) and specificity (.95) remained excellent within this age range. Similar results were observed for the school-age (AUC = .93, $p < .001$, 95% CI = .90 - .96) and pre-teen (AUC = .92, $p < .001$, 95% CI = .87 - .96) age groups. However, the optimal cutoff points were significantly lower, with the school-age children point set at 5.5 (i.e., 6 and above; Sensitivity = .84, Specificity = .83) and the pre-teen children point set at 4.5 (i.e., 5 and above; Sensitivity = .82, Specificity = .86).

As the cut points derived from the ROC analyses were lower than the points that demarcated the upper 5% of the sample, both points are included in scoring instructions. The ROC curve derived points are labeled as "Concerning" and denote a score that is significantly more likely to occur among a sample receiving treatment for PSB than in the Normative sample. The top 5% of each distribution resulted in a cut point that identified the "Problematic" range, indicating a child's score is higher than at least 95% of the normative population. Scores falling below the cut point identified in the ROC curves are labeled "Typical/Expected."

The ASB-CE: Reliability and Validity

The psychometric properties of the ASB-CE were evaluated using the normative and PA samples and established alongside those of the ASB-C.

Reliability. Items on the ASB-CE are scored in a dichotomous "yes/no" manner. The score for the measure is computed by adding the total number of positive endorsements (i.e., 0 =

No, 1 = Yes). Within the normative sample (n = 1,400), the total scale score of the ASB-CE (i.e., summation of all 38 items) displayed good internal consistency (α = .86). Internal consistency of the total scale was also good within the PA sample (α = .81). Internal consistencies of the subscales were lower, but still acceptable: *Early Development* (Normative: α = .73; PA: α = .78), *Sexual Interest* (Normative: α = .70; PA: α = .75).

Test-retest reliability of the ASB-CE was evaluated only in the PA sample (n = 151). Correlations of the two administrations were strong: Total scale (r = .83, p < .001), Early Development subscale (r = .85, p < .001), Sexual Interest subscale (r = .81, p < .01).

Validity. Convergent validity of the ASB-CE was examined in the PA sample (n = 250) by correlating the total score with the CSBI total score and the FSI. As shown in Table 7.5, positive and significant correlations were observed for all relationships.

Convergent validity in the normative sample (n = 1,400) was tested by examining the relationship of the ASB-CE scales to the various scales of the SDQ. As shown in Table 7.6, all three of the ASB-CE scales significantly and positively correlated with both clinical scales of the SDQ (emotional problems, conduct problems). In a test of discriminant validity, none of the three ASB-CE scales correlated with prosocial behavior as assessed by the SDQ.

Table 7.5: Correlations of the ASB-CE with Convergent Variables in the PA Sample

Scale	1	2	3	4	5
1. ASB-CE Total Scale	-				
2. ASB-CE Early Development subscale	.89**	-			
3. ASB-CE Sexual Interest subscale	.52**	.23**	-		
4. CSBI	.81**	.73**	.60**	-	
5. FSI	.35**	.32**	.14*	.28**	-

*p < .05, **p < .01

Table 7.6: Correlations of the ASB-CE with the SDQ in the Normative Sample

Scale	1	2	3	4	5
1. ASB-CE Total Scale	-				
2. ASB-CE Early Development subscale	.84**	-			
3. ASB-CE Sexual Interest subscale	.75**	.45**	-		
4. SDQ-Emotional Problems subscale	.27**	.23**	.23**	-	
5. SDQ-Conduct Problems subscale	.23**	.19**	.18*	.41**	-
6. SDQ-Prosocial Behavior subscale	.05	.05	<.01	-.01	-.40**

*$p < .05$, **$p < .01$

References

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

Allen, B. (2023a). Etiological pathways to the emergence of preteen problematic sexual behavior: An exploratory mediational model. *Sexual Abuse, 35*, 488-502.

Allen, B. (2023b). Etiological perspectives on problematic sexual behavior of preteen children: Implications for treatment. *Clinical Child and Family Psychology Review, 26*, 50-64.

Allen, B., & Ferrer Pistone, L. (2023). Psychometric evaluation of a single-item screening tool for the presence of problematic sexual behavior among preteen children. *Child Abuse & Neglect, 143*, 106327.

Allen, B., Silovsky, J. F., Kolko, D. J., Berliner, L., & Wamser, R. (2026). Development and psychometric validation of the Assessment of Sexual Behavior-Child Version. *Psychological Assessment*. Advanced online publication. https://psycnet.apa.org/doi/10.1037/pas0001461

Allen, B., Thorn, B. L., & Gully, K. J. (2015). A comparison of self-reported emotional and trauma-related concerns among sexually abused children with and without sexual behavior problems. *Child Maltreatment, 20*, 136-140.

Allen, B., Wamser, R. Ferrer Pistone, L., & Campbell, C. L. (2025). Problematic sexual behavior among children: A meta-analysis of demographic and clinical correlates. *Research on Child and Adolescent Psychopathology, 53*, 831-847.

Association for the Treatment and Prevention of Sexual Abusers (ATSA) Task Force on

Children with Sexual Behavior Problems. (2023). *Children with Sexual Behavior Problems* (*2nd ed.*). ATSA.

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

Brilleslijper-Kater, S. N., & Baartman, H. E. M. (2000). What do young children know about sex? Research on the sexual knowledge of children between the ages of 2 and 6 years. *Child Abuse Review, 9*, 166-182.

Cacciatore, R., Korteniemi-Poikela, E., & Kaltiala, R. (2019). The steps of sexuality – A developmental, emotion-focused, child-centered model of sexual development and sexuality education from birth to adulthood. *International Journal of Sexuality Health, 31*, 319-338.

Cacciatore, R., Öhrmark, L., Kontio, J., Apter, D., Ingman-Friberg, S., Jokela, M., Sajaniemi, N., Korkman, J., & Kaltiala, R. (2024). What do 3-6-year-old children in Finland know about sexuality? A child interview study in early education. *Sex Education, 24*, 291-310.

Cale, J., & Lussier, P. (2017). Sexual behaviour in preschool children in the context of intra-parental violence and sexual coercion. *Criminal Behaviour and Mental Health, 27*, 176-190.

Campbell, B. C. (2011). Adrenarche and middle childhood. *Human Nature, 22*, 327-349.

Chaffin, M., Berliner, L., Block, R., Johnson, T. C., Friedrich, W. N., Louis, D. G., … Silovsky, J. F. (2008). Report of the ATSA task force on children with sexual behavior problems. *Child Maltreatment, 13*, 199-218.

Cho, E., Tugendrajch, S. K., Marriott, B. R., & Hawley, K. M. (2021). Evidence-based assessment in routine mental health services for youths. *Psychiatric Services, 72*, 325-328.

Choi, J. Y., & Song, D. H. (2022). Psychometric properties of the Korean version of the Child Sexual Behavior Inventory. *Journal of Child Sexual Abuse, 31*, 805-816.

Dovgan, K., Mazurek, M. O., & Hansen, J. (2019). Measurement invariance of the child behavior checklist in children with autism spectrum disorder with and without intellectual disability: Follow-up study. *Research in Autism Spectrum Disorders, 58*, 19-29.

Elkovitch, N., Latzman, R. D., Hansen, D. J., & Flood, M. F. (2009). Understanding child sexual behavior problems: A developmental psychopathology framework. *Clinical Psychology Review, 29*, 586-598.

Ensink, K., Godbout, N., Bigras, N., Lampron, J., Sabourin, S., & Normandin, L. (2018). Persistent and transitory sexualized behavior problems in children. *Child Psychiatry and Human Development, 49*, 621-631.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*, 530-541.

Frayser, S. G. (2003). Cultural dimensions of childhood sexuality in the United States. In J. Bancroft (Ed.), *Sexual development in childhood* (pp. 255-273). Bloomington, IN: Indiana University Press.

Friedrich, W. N. (1997). *Child Sexual Behavior Inventory: Professional manual*. Lutz, FL: Psychological Assessment Resources, Inc.

Friedrich, W. N. (2007). *Children with sexual behavior problems: Family-based attachment-focused therapy*. New York: W. W. Norton & Company.

Friedrich, W. N., Davies, W. H., Feher, E., & Wright, J. (2003). Sexual behavior problems in preteen children: Developmental, ecological, and behavioral correlates. *Annals of the New York Academy of Sciences, 989*, 95-104.

Friedrich, W. N., Fisher, J., Broughton, D., Houston, M., & Shafran, C. R. (1998). Normative sexual behavior in children: A contemporary sample. *Pediatrics, 101*, e9.

Friedrich, W. N., Fisher, J. L., Dittner, C. A., Acton, R., Berliner, L., Butler, J., … Wright, J. (2001). Child Sexual Behavior Inventory: Normative, psychiatric, and sexual abuse comparisons. *Child Maltreatment, 6*, 37-49.

Friedrich, W. N., Grambsch, P., Broughton, D., Kuiper, J., & Beilke, R. L. (1991). Normative sexual behavior in children. *Pediatrics, 88*, 456-464.

Friedrich, W. N., Grambsch, P., Damon, L., Hewitt, S. K., Koverola, C., Lang, R. A., … Broughton, D. (1992). Child Sexual Behavior Inventory: Normative and clinical comparisons. *Psychological Assessment, 4*, 303-311.

Friedrich W. N., Sandfort, T. G. M., Oostveen, J., & Cohen-Kettenis, P. T. (2000). Cultural differences in sexual behavior: 2-6 Year Old Dutch and American Children. *Journal of Psychology and Human Sexuality, 12*, 117-129.

Halvorsen, M. B., Helverschou, S. B., Axelsdottir, B., Brøndbo, P. H., & Matinussen, M. (2023). General measurement tools for assessing mental health problems among children and adolescents with an intellectual disability: A systematic review. *Journal of Autism and Developmental Disabilities, 53*, 132-204.

Herdt, G., McClintock, M. (2000). The magical age of 10. *Archives of Sexual Behavior, 29*, 587-606.

Kenny, M. C., & Wurtele, S. K. (2013). Child Sexual Behavior Inventory: A comparison

between Latino and normative samples of preschoolers. *Sex Research, 50*, 449-457.

Latzman, N. E., & Latzman, R. D. (2015). Exploring the link between child sexual abuse and sexually intrusive behaviors: The moderating role of caregiver discipline strategy. *Journal of Child and Family Studies, 24*, 480-490.

Lévesque, M., Bigras, M., & Pauzé, R. (2010). Externalizing problems and problematic sexual behaviors: Same etiology? *Aggressive Behavior, 36*, 358-370.

Lévesque, M., Bigras, M., & Pauzé, R. (2012). Persistence of problematic sexual behaviors in children. *Journal of Clinical Child and Adolescent Psychology, 41*, 239-245.

Lussier, P., McCuish, E., Mathesius, J., Corrado, R., & Nadeau, D. (2018). Developmental trajectories of child sexual behaviors on the path of sexual behavioral problems: Evidence from a prospective longitudinal study. *Sexual Abuse, 30*, 622-658.

Mandel, A., & Datner, E. (2017). Sexual behaviors in children with developmental disabilities. *Journal of Alternative Medicine Research, 9,* 257-283.

Merrick, M. T., Litrownik, A. J., Everson, M. D., & Cox, C. E. (2008). Beyond sexual abuse: The impact of other maltreatment experiences on sexualized behaviors. *Child Maltreatment, 13*, 122-132.

Mori, C., Park, J., Racine, N., Ganshorn, H., Hartwick, C., & Madigan, S. (2023). Exposure to sexual content and problematic sexual behaviors in children and adolescents: A systematic review and meta-analysis. *Child Abuse & Neglect, 143*, 106255.

Silovsky, J.F. (2009). *Taking action: Support for families of children with sexual behavior problems.* Vermont: Safer Society Press.

Silovsky, J. F. & Niec, L. (2002). Characteristics of young children with sexual behavior problems: A pilot study. *Child Maltreatment, 7*, 187-197.

Silovsky, J. F., Niec, L., Bard, D., & Hecht, D. B. (2007). Treatment for preschool children with interpersonal sexual behavior problems: A pilot study. *Journal of Clinical Child and Adolescent Psychology, 36*, 378-391.

Simmons, J., Barton, N., Lopez, K., Taylor, E., & Silovsky, J.F. (in press). Child maltreatment and trauma symptoms role in the development of intrusive sexual behaviors among children. *Journal of Child Sexual Abuse*.

Smith, T. J., Lindsey, R. A., Bohora, S., & Silovsky, J. F. (2019). Predictors of intrusive sexual behaviors in preschool-aged children. *The Journal of Sex Research, 56*, 229-238.

Thigpen, J. W. (2009). Early sexual behavior in a sample of low-income, African American children. *Journal of Sex Research, 46*, 67-79.

Tremblay, M.-J., Daignault, I. V., Fontaine, N. M. G., Boisvert, I., & Tourigny, M. (2020). School-aged children with sexual behavior problems: Untangling the relationship between externalizing behavior problems and non-sexual victimization on the variety and severity of sexual behaviors. *Child Abuse & Neglect, 107*, 104490.

Wamser-Nanney, R., & Campbell, C. L. (2019). Children's sexual behavior problems: An ecological model using the LONGSCAN data. *Child Abuse & Neglect, 96*, 104085.

Wamser-Nanney, R., & Campbell, C. L. (2020). Childhood sexual abuse characteristics, abuse stress, and PTSS: Ties to sexual behavior problems. *Child Abuse & Neglect, 105*, 104290.

Wamser-Nanney, R., & Campbell, C. L. (2022). Sexual behavior problems among sexually abused children: Associations with co-occurring symptoms. *Child Maltreatment, 27*, 78-87.

Wamser-Nanney, R., Sager, J. C., & Campbell, C. L. (2019). Maternal support as a predictor of

children's sexualized behaviors following childhood sexual abuse. *Child Maltreatment, 24*, 36-44.

Appendix A: Demographic Information of Validation Samples

Appendix A.1: Demographics of the Normative Sample

Demographic Variable	*Total Scale*[a]	*Early Development Subscale*[b]	*Sexual Interest Subscale*[c]	Analysis
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	
Child Gender:				[a]*t* = .46
-Male (*n* = 681)	2.58 (3.96)	1.08 (2.30)	.32 (1.09)	[b]*t* = 2.48*
-Female (*n* = 714)	2.45 (6.07)	.77 (2.25)	.44 (1.59)	[c]*t* = 1.57
Child Race/Ethnicity:				[a]*F* = 7.15***
-White/Caucasian (*n* = 814)	2.95 (5.96)	1.38 (2.52)	.49 (1.64)	[b]*F* = 9.98***
-Black/African-Am. (*n* = 147)	2.34 (4.03)	.53 (1.63)	.23 (.88)	[c]*F* = 4.44**
-Hispanic/Latino (*n* = 268)	1.29 (2.26)	.36 (.97)	.21 (.76)	
-Other (*n* = 161)	2.48 (4.68)	1.11 (2.76)	.24 (.88)	
•Asian/Asian-Am. (*n* = 58)	1.57 (2.55)	.47 (1.12)	.07 (.47)	
•Hawaiian/Pac. Island. (*n* = 3)	1.30 (1.16)	1.30 (1.16)	.00 (.00)	
•Native Am./Alaskan (*n* = 16)	1.65 (2.18)	.48 (1.01)	.28 (.46)	
•Multiple Ethnicities (*n* = 76)	3.51 (6.16)	1.81 (3.74)	.39 (1.18)	
•Other reported (*n* = 7)	1.29 (2.66)	.28 (.49)	.00 (.00)	
Caregiver Gender:				[a]*t* = .44
-Male (*n* = 573)	2.44 (5.86)	.76 (1.98)	.46 (1.57)	[b]*t* = 2.30*
-Female (*n* = 827)	2.56 (4.58)	1.03 (2.46)	.33 (1.21)	[c]*t* = 1.70
Caregiver Race/Ethnicity:				[a]*F* = 6.32***
-White/Caucasian (*n* = 835)	2.94 (5.91)	1.15 (2.49)	.48 (1.62)	[b]*F* = 10.25***
-Black/African-Am. (*n* = 154)	2.14 (3.20)	.45 (1.35)	.20 (.75)	[c]*F* = 3.43*
-Hispanic/Latino (*n* = 259)	1.39 (2.94)	.38 (1.20)	.25 (.80)	
-Other (*n* = 152)	2.42 (4.80)	1.07 (2.90)	.26 (1.02)	
•Asian/Asian-Am. (*n* = 68)	1.81 (3.29)	.71 (2.01)	.09 (.47)	
•Hawaiian/Pac. Island. (*n* = 0)	--	--	--	
•Native Am./Alaskan (*n* = 18)	1.66 (2.01)	.36 (.91)	.20 (.41)	
•Multiple Ethnicities (*n* = 40)	4.31 (7.60)	2.33 (4.68)	.52 (1.60)	
•Other reported (*n* = 27)	1.90 (3.13)	.58 (1.19)	.41 (1.34)	
Relationship to Child:				[a]*t* = 2.38*
-Biological Parent (*n* = 1,315)	2.44 (5.12)	.90 (2.28)	.36 (1.35)	[b]*t* = 1.39
-"Surrogate" (*n* = 80)	3.84 (4.98)	1.27 (2.33)	.70 (1.62)	[c]*t* = 1.84
•Kin relationship (*n* = 25)	2.57 (3.66)	.88 (1.98)	.52 (1.37)	
•Step-parent (*n* = 22)	3.85 (4.15)	1.14 (2.30)	1.35 (2.41)	
•Adoptive parent (*n* = 25)	4.40 (4.14)	1.48 (2.29)	.31 (.96)	
•Foster parent (*n* = 2)	9.48 (16.89)	3.89 (7.74)	1.71 (1.41)	
•Other reported (*n* = 6)	4.92 (4.07)	1.69 (2.32)	.46 (.54)	
Household Income (annual):				[a]*F* = 3.03*
-Less than $30,000 (*n* = 187)	2.14 (3.62)	.56 (1.71)	.40 (1.29)	[b]*F* = 4.68***
-$30,000 - $60,000 (*n* = 270)	1.94 (3.62)	.72 (1.82)	.27 (1.03)	[c]*F* = 1.43
-$60,000 - $90,000 (*n* = 325)	2.33 (3.58)	.87 (1.87)	.37 (1.12)	
-$90,000 - $120,000 (*n* = 196)	2.97 (7.51)	.92 (2.48)	.57 (1.97)	
-More than $120,000 (*n* = 356)	3.19 (6.42)	1.34 (2.98)	.41 (1.51)	

Note: Numbers may not equal to 1,400 because of declinations in answers
*$p < .05$, **$p < .01$, ***$p < .001$.

Appendix A.2: Demographics of the Pennsylvania Sample

Demographic Variable	*Total Scale*[a]	*Early Development Subscale*[b]	*Sexual Interest Subscale*[c]	Analysis
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	
Child Gender:				[a]$t = 1.22$
-Male ($n = 122$)	5.85 (6.68)	2.94 (4.10)	.88 (2.05)	[b]$t = 2.08$*
-Female ($n = 148$)	4.87 (6.47)	1.97 (3.46)	.71 (1.92)	[c]$t = .69$
Child Race/Ethnicity:				[a]$F = .96$
-White/Caucasian ($n = 161$)	5.76 (6.87)	2.84 (4.09)	.71 (1.90)	[b]$F = 2.18$
-Black/African-Am. ($n = 44$)	4.77 (5.94)	1.48 (2.18)	1.27 (2.86)	[c]$F = 1.08$
-Hispanic/Latino ($n = 32$)	3.75 (5.12)	1.53 (2.33)	.67 (1.38)	
-Other ($n = 33$)	5.38 (7.12)	2.42 (4.70)	.64 (1.29)	
•Asian/Asian-Am. ($n = 7$)	2.14 (3.63)	1.57 (3.31)	.00 (.00)	
•Hawaiian/Pac. Island. ($n = 1$)	--	--	--	
•Native Am./Alaskan ($n = 1$)	--	--	--	
•Multiple Ethnicities ($n = 21$)	6.67 (8.24)	2.86 (5.43)	.86 (1.49)	
•Other reported ($n = 2$)	3.50 (.71)	2.00 (2.83)	.00 (.00)	
Caregiver Gender:				[a]$t = .92$
-Male ($n = 30$)	6.37 (6.10)	3.30 (3.63)	1.00 (2.23)	[b]$t = 1.35$
-Female ($n = 241$)	5.20 (6.62)	2.32 (3.80)	.76 (1.95)	[c]$t = .64$
Caregiver Race/Ethnicity:				[a]$F = .50$
-White/Caucasian ($n = 187$)	5.63 (6.81)	2.80 (4.19)	.66 (1.80)	[b]$F = 2.05$
-Black/African-Am. ($n = 39$)	4.64 (5.99)	1.38 (2.20)	1.28 (2.95)	[c]$F = 1.09$
-Hispanic/Latino ($n = 23$)	4.22 (6.09)	1.70 (2.57)	.91 (1.88)	
-Other ($n = 21$)	5.10 (5.94)	1.86 (3.01)	.77 (1.31)	
•Asian/Asian-Am. ($n = 2$)	8.0 (8.49)	1.00 (1.41)	.50 (.71)	
•Hawaiian/Pac. Island. ($n = 0$)	--	--	--	
•Native Am./Alaskan ($n = 0$)	--	--	--	
•Multiple Ethnicities ($n = 11$)	6.91 (6.44)	2.33 (3.23)	1.33 (1.56)	
•Other reported ($n = 8$)	1.88 (3.44)	1.38 (3.11)	.00 (.00)	
Relationship to Child:				[a]$t = 1.13$
-Biological Parent ($n = 253$)	5.08 (6.19)	2.38 (3.79)	.70 (1.76)	[b]$t = .34$
-"Surrogate" ($n = 17$)	7.71 (9.46)	2.71 (3.65)	1.53 (3.34)	[c]$t = 1.02$
•Kin relationship ($n = 5$)	9.40 (10.29)	3.60 (4.93)	2.40 (2.19)	
•Step-parent ($n = 3$)	10.67 (18.48)	3.33 (5.77)	4.33 (7.51)	
•Adoptive parent ($n = 6$)	5.00 (2.68)	1.33 (1.51)	.17 (.41)	
•Foster parent ($n = 1$)	--	--	--	
•Other reported ($n = 2$)	1.50 (.71)	1.50 (.71)	.00 (.00)	
Household Income (annual):				[a]$F = 1.57$
-Less than $30,000 ($n = 55$)	4.82 (6.16)	1.76 (3.02)	1.02 (2.48)	[b]$F = 2.23$
-$30,000 - $60,000 ($n = 67$)	4.65 (5.85)	1.69 (2.84)	.65 (1.78)	[c]$F = .41$
-$60,000 - $90,000 ($n = 61$)	7.07 (8.43)	3.38 (5.07)	.77 (1.62)	
-$90,000 - $120,000 ($n = 33$)	4.18 (5.10)	2.45 (3.60)	.55 (.97)	
-More than $120,000 ($n = 55$)	5.45 (6.09)	2.86 (3.74)	.86 (2.40)	

Note: Numbers may not equal to 271 because of declinations in answers
*$p < .05$, **$p < .01$, ***$p < .001$.

Appendix A.3: Demographics of the Clinical Sample

Demographic Variable	*Total Scale*[a]	*Early Development Subscale*[b]	*Sexual Interest Subscale*[c]	Analysis
	M (*SD*)	*M* (*SD*)	*M* (*SD*)	
Child Gender:				[a]$t = .75$
-Male ($n = 72$)	17.63 (13.26)	7.47 (5.56)	3.14 (4.44)	[b]$t = .71$
-Female ($n = 38$)	19.61 (13.04)	8.29 (5.99)	3.68 (4.38)	[c]$t = .62$
Child Race/Ethnicity:				[a]$F = 2.16$
-White/Caucasian ($n = 72$)	17.54 (13.06)	7.89 (5.61)	2.54 (3.67)	[b]$F = 2.81$*
-Black/African-Am. ($n = 15$)	25.73 (14.04)	10.67 (5.38)	5.60 (6.01)	[c]$F = 3.26$*
-Hispanic/Latino ($n = 19$)	15.00 (12.31)	5.16 (5.68)	3.81 (.87)	
-Other ($n = 4$)	20.00 (7.87)	6.75 (4.27)	7.00 (8.52)	
Caregiver Gender:				[a]$t =$ .59
-Male ($n = 25$)	19.68 (14.11)	8.56 (6.44)	3.44 (3.78)	[b]$t =$ .81
-Female ($n = 85$)	17.91 (12.92)	7.52 (5.47)	3.29 (4.60)	[c]$t =$ .15

Note: Numbers may not equal to 110 because of declinations in answers
*$p < .05$, **$p < .01$, ***$p < .001$.

Appendix B: Mean Item Scores of the Validation Samples

Appendix B.1: Mean item scores on the ASB-C

Item	Normative Sample *M* (*SD*)	Pennsylvania Sample *M* (*SD*)	Clinical Sample *M* (*SD*)
1. Stands or sits too close to others.	.55 (1.06)	.76 (1.21)	2.1 (1.57)
2. Hugs people they do not know well.	.19 (.59)	.31 (.77)	.71 (1.15)
3. Kisses people they do not know well.	.03 (.21)	.06 (.30)	.19 (.64)
4. Touches or tries to touch the breasts of others.	.06 (.34)	.18 (.58)	.50 (.93)
5. Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	.30 (.65)	.76 (1.01)	.95 (1.09)
6. Asks questions about private parts and/or sexual acts to people other than a trusted adult.	.04 (.23)	.08 (.39)	.29 (.71)
7. Views non-sexual things or topics in a sexual way.	.03 (.26)	.07 (.32)	.59 (1.01)
8. Uses the internet to seek out information on sexual topics.	.05 (.29)	.12 (.48)	.39 (.96)
9. Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	.17 (.57)	.44 (.88)	1.27 (1.40)
10. Uses sexual words in an insulting, disrespectful, and/or suggestive way.	.05 (.35)	.04 (.26)	.34 (.88)
11. Plays with toys in a sexual way, draws pictures or writes about private parts or sexual topics.	.02 (.18)	.06 (.32)	.38 (.91)
12. Moves, dances, or makes hand gestures that are sexually suggestive.	.09 (.40)	.22 (.61)	.76 (1.16)
13. Looks at or ties to look at others who are nude, undressing, and/or toileting.	.11 (.44)	.44 (.92)	1.21 (1.34)
14. Looks at or tries to look at people engaged in sexual acts.	.02 (.18)	.05 (.27)	.18 (.68)
15. Looks at pictures or videos that show nudity or sexual acts.	.06 (.35)	.12 (.42)	.39 (.92)
16. Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	.01 (.15)	.03 (.22)	.18 (.68)
17. Touches or rubs own private parts when alone.	.19 (.64)	.33 (.81)	1.49 (1.51)
18. Touches or rubs private parts when around other people.	.08 (.42)	.17 (.60)	.95 (1.35)
19. Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	.03 (.26)	.10 (.38)	.68 (1.17)
20. Inserts or tries to insert objects inside own private parts.	.01 (.16)	.03 (.25)	.10 (.47)
21. Shows own private parts to others.	.06 (.34)	.20 (.56)	.77 (1.01)
22. Shows picture(s) of their own or other people's private parts to others.	.01 (.13)	.01 (.12)	.11 (.46)
23. Asks others to show their private parts or engage in sexual acts while talking in-person.	.01 (.13)	.01 (.12)	.35 (.68)

24. Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	<.01 (.09)	.03 (.20)	.09 (.46)
25. Uses digital media to ask others to send them pictures or videos showing nudity or sexual acts.	.01 (.12)	.02 (.16)	.06 (.41)
26. Coerces others to send sexual pictures or videos in a digital format.	.01 (.13)	<.01 (<.01)	Not endorsed
27. Threatens to share sexual pictures or videos of others.	<.01 (.06)	.01 (.18)	.03 (.21)
28. Strokes, massages, or caresses the bodies of others.	.02 (.18)	.04 (.28)	.37 (.78)
29. Rubs private parts on other people.	.01 (.16)	.01 (.12)	.22 (.61)
30. Slaps or pokes the buttocks of others.	.20 (.61)	.56 (.98)	.88 (1.24)
31. Touches or tries to touch the private parts of others.	.02 (.18)	.01 (.11)	.54 (.94)
32. Puts mouth on the breasts or private parts of others.	.01 (.12)	.01 (.14)	.20 (.60)
33. Inserts or tries to insert objects in another child's private parts.	.01 (.11)	<.01 (.06)	.01 (.10)
34. Tries to undress others against their will.	.01 (.13)	.01 (.09)	.16 (.50)
35. Plans to get others to engage in sexual behavior.	<.01 (.10)	<.01 (.06)	.16 (.50)
36. Coerces others to engage in sexual behavior.	<.01 (.08)	<.01 (<.01)	.12 (.46)
37. Performs sexual behaviors with an animal.	.01 (.11)	<.01 (.06)	.05 (.28)
38. Continues to engage in sexual behavior after being told to stop.	.02 (.19)	.03 (.22)	.54 (1.04)

Appendix C: Mean Scale Scores of the Validation Samples

Appendix C.1: Mean Scale Scores for Complete Samples

Item	Normative Sample *M* (*SD*)	Pennsylvania Sample *M* (*SD*)	Clinical Sample *M* (*SD*)
Total Scale	2.51 (5.14)	5.33 (6.56)	18.31 (13.16)
Early Development Subscale	0.92 (2.28)	2.42 (3.78)	7.75 (5.69)
Sexual Interest Subscale	0.38 (1.37)	0.78 (1.98)	3.33 (4.41)

Appendix C.2: Mean Scale Scores for Ages 3-5

Item	Normative Sample *M* (*SD*)	Pennsylvania Sample *M* (*SD*)	Clinical Sample *M* (*SD*)
Total Scale	2.94 (4.25)	6.61 (7.49)	20.89 (11.90)
Early Development Subscale	1.67 (2.55)	3.55 (4.83)	10.54 (5.31)
Sexual Interest Subscale	0.12 (0.53)	0.22 (0.76)	2.54 (3.32)

*Normative *n* = 356; Pennsylvania *n* = 107; Clinical *n* = 28.

Appendix C.3: Mean Scale Scores for Ages 6-9

Item	Normative Sample *M* (*SD*)	Pennsylvania Sample *M* (*SD*)	Clinical Sample *M* (*SD*)
Total Scale	2.64 (4.83)	4.54 (5.01)	17.76 (12.82)
Early Development Subscale	1.07 (2.45)	1.99 (2.78)	7.69 (5.71)
Sexual Interest Subscale	0.40 (1.25)	0.69 (1.58)	3.02 (3.52)

*Normative *n* = 577; Pennsylvania *n* = 85; Clinical *n* = 55.

Appendix C.3: Mean Scale Scores for Ages 10-12

Item	Normative Sample *M* (*SD*)	Pennsylvania Sample *M* (*SD*)	Clinical Sample *M* (*SD*)
Total Scale	2.03 (6.05)	4.44 (6.51)	16.74 (15.07)
Early Development Subscale	0.54 (1.71)	1.37 (2.54)	5.00 (4.77)
Sexual Interest Subscale	0.56 (1.84)	1.63 (2.98)	4.78 (6.42)

*Normative *n* = 458; Pennsylvania *n* = 79; Clinical *n* = 27

Appendix D: **Distribution of Scores in the Normative Sample**

Appendix D.1: Distribution of Scores for Total Sample

Raw Score	*Total Scale* (%ile)	*Early Development Subscale* (%ile)	*Sexual Interest Subscale* (%ile)
0	43.5	71.3	85.6
1	56.9	80.5	91.9
2	69.9	86.8	95.5
3	75.7	90.3	96.4
4	81.6	94.0	97.8
5	85.2	95.7	98.6
6	88.7	96.3	99.1
7	91.5	97.2	>99.1
8	93.2	97.9	>99.1
9	94.3	98.4	>99.1
10	95.1	99.0	>99.1
11	96.0	>99.0	>99.1
12	96.4	>99.0	>99.1
13	96.9	>99.0	>99.1
14	97.6	>99.0	>99.1
15	98.2	>99.0	>99.1
16	98.6	>99.0	>99.1
17	98.8	>99.0	>99.1
18+	>98.8	>99.0	>99.1

n = 1397

Appendix D.2: Distribution of Scores for Ages 3-5 Years

Raw Score	*Total Scale* (%ile)	*Early Development Subscale* (%ile)	*Sexual Interest Subscale* (%ile)
0	38.0	66.5	93.3
1	50.5	77.2	97.4
2	65.0	82.7	98.8
3	69.3	87.3	>99.0
4	76.8	91.6	>99.0
5	80.3	93.6	>99.0
6	84.4	93.9	>99.0
7	87.3	95.4	>99.0
8	91.1	96.8	>99.0
9	92.8	97.4	>99.0
10	93.7	98.6	>99.0
11	95.4	>99.0	>99.0
12	95.7	>99.0	>99.0
13	96.2	>99.0	>99.0
14	97.4	>99.0	>99.0
15	97.7	>99.0	>99.0
16	98.3	>99.0	>99.0
17	98.6	>99.0	>99.0
18+	>98.6	>99.0	>99.0

n = 345

Appendix D.3: Distribution of Scores for Ages 6-9 Years

Raw Score	*Total Scale* (%ile)	*Early Development Subscale* (%ile)	*Sexual Interest Subscale* (%ile)
0	39.4	66.7	83.3
1	54.0	76.8	91.4
2	68.0	84.7	95.7
3	73.7	88.5	96.7
4	79.7	92.3	98.1
5	83.6	94.7	98.6
6	88.3	95.7	99.1
7	91.7	96.7	>99.1
8	93.1	97.4	>99.1
9	94.1	98.1	>99.1
10	95.0	98.8	>99.1
11	95.5	99.1	>99.1
12	96.0	>99.1	>99.1
13	96.6	>99.1	>99.1
14	97.4	>99.1	>99.1
15	97.9	>99.1	>99.1
16	98.3	>99.1	>99.1
17	98.6	>99.1	>99.1
18+	>98.6	>99.1	>99.1

n = 582

Appendix D.4: Distribution of Scores for Ages 10-12 Years

Raw Score	*Total Scale* (%ile)	*Early Development Subscale* (%ile)	*Sexual Interest Subscale* (%ile)
0	52.7	80.6	82.6
1	65.3	87.6	88.5
2	76.0	92.3	92.8
3	82.9	94.9	94.1
4	87.4	97.9	96.0
5	90.8	98.5	97.5
6	92.3	98.9	98.5
7	94.2	99.1	98.9
8	94.9	99.4	99.2
9	95.7	>99.4	>99.2
10	96.4	>99.4	>99.2
11	97.0	>99.4	>99.2
12	97.4	>99.4	>99.2
13	97.9	>99.4	>99.2
14	98.1	>99.4	>99.2
15	98.9	>99.4	>99.2
16	99.4	>99.4	>99.2
17	>99.4	>99.4	>99.2
18+	>99.4	>99.4	>99.2

n = 467

Appendix E: Brief Summary of the ASB-C

What Is It?

The Assessment of Sexual Behavior-Child Version (ASB-C) is a caregiver-report instrument that asks a caregiver to report the frequency with which a child (ages 3-12) performed 38 separate sexual behaviors over the past month. The items include both typical and problematic forms of sexual behavior.

Is it Valid and Reliable?

Yes. The ASB-C was tested in three separate samples that collectively included over 1,700 children/caregivers. The normative sample was nationally representative, the psychometric characteristics are strong, and results are available in the ASB-C manual.

What Information Does It Provide?

The ASB-C includes several items that describe behaviors that are themselves problematic (e.g., "critical items"). Also, a total score can be calculated to determine if the overall frequency of the child's behaviors exceeds what is typical for a given age.

Is It Easy to Score and Interpret?

Yes. Scoring instructions are available on the other side of this page. It was designed to be easy to administer, score, and interpret by clinicians in community practice.

How Much Does It Cost?

The use of the ASB-C is free for clinicians and researchers.

How do I Explain it to Caregivers?

"This checklist asks about various sexual behaviors children may display. Some behaviors are relatively common among children while others are rarer. We give this measure in the interests of being thorough in our assessment and recognize that many of the items on this measure won't be relevant to many families. If there are any items that you are concerned about, we can discuss them. Also, I may ask follow-up questions afterwards to help me better your answers."

Appendix F: ASB-C Scoring Summary

Total Score:
To calculate the Total Score - add all the scores for the 38 items together. To find out where this score falls on the continuum of sexual behavior (Typical/Expected, Concerning, or Problematic), find the row that matches the age of the child and then find the column or score range within which the Total Score falls.

Age group	Typical/Expected	Concerning	Problematic
3-5 years	0-10	11	12-152
6-9 years	0-6	7-10	11-152
10-12 years	0-5	6-9	10-152

Critical Items:
These behaviors are rare (less than 1% of children) and are considered potentially problematic when present. Critical items should be reviewed and directly addressed.

#	Question
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.
20.	Inserts or tries to insert objects inside ***own*** private parts.
22.	Shows picture(s) of their own or other people's private parts to others.
23.	Asks others to show their private parts or engage in sexual acts while talking **in-person.**
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).
26.	Coerces others to send sexual pictures or videos.
27.	Threatens to share sexual pictures or videos of others.
29.	Rubs private parts on other people.
31.	Touches or tries to touch the private parts of others
32.	Puts mouth on the breasts or private parts of others.
33.	Inserts or tries to insert objects in ***another child's*** private parts
34.	Tries to undress others against their will.
35.	Plans to get others to engage in sexual behavior.
36.	Coerces others to engage in sexual behavior.
37.	Performs sexual behaviors with an animal.
38.	Continues to engage in sexual behavior after being told to stop.

Scoring Process:
1. Calculate the Total Score and determine where it falls for the age of the child.
2. Identify "Critical Items" endorsed by caregiver.
3. Integrate presence of critical items (clinically give more weight) with total summed score for an overall clinical impression.
4. Integrate findings with the other aspects of the evaluation (interviews, measures)
5. Provide everyday language feedback and engage in shared treatment planning.

Appendix G: Additional Resources

All of the following materials are currently available, or soon will be, at: https://connect.ncsby.org/assessingpsb/resources

Training

1. Free recorded webinar (40 minutes): *Administration, Scoring, and Interpretation of the Assessment of Sexual Behavior: Child Version (ASB-C)*

Materials (free and downloadable)

1. The Assessment of Sexual Behavior-Child Version (ASB-C): A Manual for Administration, Scoring, and Interpretation
2. The ASB-C test protocol
3. The ASB-CE test protocol
4. The ASB-C Score Form
5. The *Brief Summary of the ASB-C* (Appendix E)
6. The *ASB-C Scoring Summary* (Appendix F)

Translations Available

1. Spanish
2. Swedish
3. Dutch
4. Polish

ASB-C

The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the **PAST MONTH** using the scale provided.

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
1.	Stands or sits too close to others.	0	1	2	3	4
2.	Hugs people they do not know well.	0	1	2	3	4
3.	Kisses people they do not know well.	0	1	2	3	4
4.	Touches or tries to touch the breasts of others.	0	1	2	3	4
5.	Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	0	1	2	3	4
6.	Asks questions about private parts and/or sexual acts to people other than a trusted adult.	0	1	2	3	4
7.	Views non-sexual things or topics in a sexual way.	0	1	2	3	4
8.	Uses the internet to seek out information on sexual topics.	0	1	2	3	4
9.	Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	0	1	2	3	4
10.	Uses sexual words in an insulting, disrespectful, and/or suggestive way.	0	1	2	3	4
11.	Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	0	1	2	3	4
12.	Moves, dances, or makes hand gestures that are sexually suggestive.	0	1	2	3	4
13.	Looks at or tries to look at others who are nude, undressing, and/or toileting.	0	1	2	3	4
14.	Looks at or tries to look at people engaged in sexual acts.	0	1	2	3	4
15.	Looks at pictures or videos that show nudity or sexual acts.	0	1	2	3	4
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	0	1	2	3	4
17.	Touches or rubs own private parts when ***alone***.	0	1	2	3	4
18.	Touches or rubs private parts when around ***other people***.	0	1	2	3	4
19.	Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	0	1	2	3	4
20.	Inserts or tries to insert objects inside ***own*** private parts.	0	1	2	3	4
21.	Shows own private parts to others.	0	1	2	3	4
22.	Shows picture(s) of their own or other people's private parts to others.	0	1	2	3	4
23.	Asks others to show their private parts or engage in sexual acts while talking **in-person**.	0	1	2	3	4

		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	0	1	2	3	4
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).	0	1	2	3	4
26.	Coerces others to send sexual pictures or videos. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	0	1	2	3	4
27.	Threatens to share sexual pictures or videos of others.	0	1	2	3	4
28.	Strokes, massages, or caresses the bodies of others.	0	1	2	3	4
29.	Rubs private parts on other people.	0	1	2	3	4
30.	Slaps or pokes the buttocks of others.	0	1	2	3	4
31.	Touches or tries to touch the private parts of others.	0	1	2	3	4
32.	Puts mouth on the breasts or private parts of others.	0	1	2	3	4
33.	Inserts or tries to insert objects in ***another child's*** private parts.	0	1	2	3	4
34.	Tries to undress others against their will.	0	1	2	3	4
35.	Plans to get others to engage in sexual behavior.	0	1	2	3	4
36.	Coerces others to engage in sexual behavior. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	0	1	2	3	4
37.	Performs sexual behaviors with an animal.	0	1	2	3	4
38.	Continues to engage in sexual behavior after being told to stop.	0	1	2	3	4

***Please tell us of any other sexual behaviors your child has displayed that were not mentioned above:

_____

***The questions below are to help us better understand the behaviors you described above.
Note: *If you answered "0" (Never) to all the questions above, you do not need to complete the section below.*

A. With whom did your child engage in any of the behaviors above (check all that apply):

☐ Children who live in the same home (such as siblings)
☐ Children who do not live in the same home (such as cousins)
☐ Children at school (such as schoolmates)
☐ Children with developmental delays or disabilities
☐ Children with another vulnerability (please describe): _____
☐ Strangers or people they do not know well
☐ Neighbor(s)
☐ Adult(s)
☐ Children who are younger

B. Where did the behaviors you reported above occur (check all that apply):

☐ Home
☐ School/preschool/school bus
☐ Other (please describe):_____
☐ Neighbor's house
☐ Childcare provider
☐ Public setting (such as stores)
☐ Outside (such as a playground)

C. During any of the behaviors you reported above, did your child use coercion, such as force, threats, pressure, bribery, and/or trickery?

☐ No ☐ Yes (please describe):_____

ASB-C Score Form

Step 1: Critical Items

Check each item below with a non-0 response (i.e., 1, 2, 3, 4).

16. _____	26. _____	34. _____
20. _____	27. _____	35. _____
22. _____	29. _____	36. _____
23. _____	31. _____	37. _____
24. _____	32. _____	38. _____
25. _____	33. _____	

Step 2: Total Scale Score

Sum all item scores (#1 - #38).

Total Score = _____

Step 3: Total Score Interpretation

Circle the appropriate answer based on the child's age and total scale score

Age Group	*Typical/Expected*	*Concerning*	*Problematic*
3 – 5 years	0 – 10	11	12 – 152
6 – 9 years	0 – 6	7 – 10	11 – 152
10 – 12 years	0 – 5	6 – 9	10 – 152

Step 4: Final Interpretation

a. If any critical items are checked in Step 1, the child's behavior is considered *Problematic* and clinical services are likely indicated. (Interpretation of the Total Scale score may be helpful, but is not necessary to classify behavior as "problematic.")

b. In Step 3, a score in the *Concerning* range indicates the child's pattern of behavior is more likely to occur among clinical samples of children with problematic behavior. Further assessment is advised.

c. In Step 3, a score in the *Problematic* range indicates the score is among the highest 5% in the normative population. Clinical services are likely indicated.

ASB-CE

The items below describe various types of behaviors. Some items refer to behaviors involving private parts (such as penis, vagina, or rectum) or sexual acts. Please report how often your child has shown the following behaviors in the **PAST MONTH** using the scale provided. Also, please indicate whether your child has displayed each behavior at any time during the past **SIX (6) MONTHS**.

		PAST MONTH					**SIX (6) MONTHS**	
		How often has your child shown the following behaviors in the PAST MONTH?					Has your child shown the behaviors in the past SIX (6) MONTHS?	
		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times	NO	YES
1.	Stands or sits too close to others.	0	1	2	3	4	N	Y
2.	Hugs people they do not know well.	0	1	2	3	4	N	Y
3.	Kisses people they do not know well.	0	1	2	3	4	N	Y
4.	Touches or tries to touch the breasts of others.	0	1	2	3	4	N	Y
5.	Asks questions about private parts and/or sexual acts to a trusted adult (such as a parent or teacher).	0	1	2	3	4	N	Y
6.	Asks questions about private parts and/or sexual acts to people other than a trusted adult.	0	1	2	3	4	N	Y
7.	Views non-sexual things or topics in a sexual way.	0	1	2	3	4	N	Y
8.	Uses the internet to seek out information on sexual topics.	0	1	2	3	4	N	Y
9.	Talks about private parts, sexual topics, or toileting behaviors at inappropriate times.	0	1	2	3	4	N	Y
10.	Uses sexual words in an insulting, disrespectful, and/or suggestive way.	0	1	2	3	4	N	Y
11.	Plays with toys in a sexual way; draws pictures or writes about private parts or sexual topics.	0	1	2	3	4	N	Y
12.	Moves, dances, or makes hand gestures that are sexually suggestive.	0	1	2	3	4	N	Y
13.	Looks at or tries to look at others who are nude, undressing, and/or toileting.	0	1	2	3	4	N	Y
14.	Looks at or tries to look at people engaged in sexual acts.	0	1	2	3	4	N	Y
15.	Looks at pictures or videos that show nudity or sexual acts.	0	1	2	3	4	N	Y

		PAST MONTH					SIX (6) MONTHS	
		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times	NO	YES
16.	Looks at pictures or videos of violent, aggressive, and/or extreme sex acts.	0	1	2	3	4	N	Y
17.	Touches or rubs own private parts when ***alone***.	0	1	2	3	4	N	Y
18.	Touches or rubs private parts when around ***other people***.	0	1	2	3	4	N	Y
19.	Rubs private parts on or with an object (such as furniture, toy, blanket, remote control).	0	1	2	3	4	N	Y
20.	Inserts or tries to insert objects inside ***own*** private parts.	0	1	2	3	4	N	Y
21.	Shows own private parts to others.	0	1	2	3	4	N	Y
22.	Shows picture(s) of their own or other people's private parts to others.	0	1	2	3	4	N	Y
23.	Asks others to show their private parts or engage in sexual acts while talking **in-person**.	0	1	2	3	4	N	Y
24.	Sends sexual messages, pictures, and/or videos to others (such as through email, texts, social media).	0	1	2	3	4	N	Y
25.	Asks others to send them pictures or videos showing nudity or sexual acts (such as through email, texts, social media).	0	1	2	3	4	N	Y
26.	Coerces others to send sexual pictures or videos. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	0	1	2	3	4	N	Y
27.	Threatens to share sexual pictures or videos of others.	0	1	2	3	4	N	Y
28.	Strokes, massages, or caresses the bodies of others.	0	1	2	3	4	N	Y
29.	Rubs private parts on other people.	0	1	2	3	4	N	Y
30.	Slaps or pokes the buttocks of others.	0	1	2	3	4	N	Y
31.	Touches or tries to touch the private parts of others.	0	1	2	3	4	N	Y

		PAST MONTH					SIX (6) MONTHS	
		Never	1 time (Once)	2-4 times	5-10 times	More than 10 times	NO	YES
32.	Puts mouth on the breasts or private parts of others.	0	1	2	3	4	N	Y
33.	Inserts or tries to insert objects in ***another child's*** private parts.	0	1	2	3	4	N	Y
34.	Tries to undress others against their will.	0	1	2	3	4	N	Y
35.	Plans to get others to engage in sexual behavior.	0	1	2	3	4	N	Y
36.	Coerces others to engage in sexual behavior. (Note: 'coerces' means using force, threats, pressure, bribery, and/or trickery)	0	1	2	3	4	N	Y
37.	Performs sexual behaviors with an animal.	0	1	2	3	4	N	Y
38.	Continues to engage in sexual behavior after being told to stop.	0	1	2	3	4	N	Y

***Please tell us of any other sexual behaviors your child has displayed that were not mentioned above:

_____

***The questions below are to help us better understand the behaviors you described above.
Note: *If you answered "0" (Never) and "No" to all the questions above, you do not need to complete the section below.*

A. With whom did your child engage in any of the behaviors above (check all that apply):

☐ Children who live in the same home (such as siblings)
☐ Children who do not live in the same home (such as cousins)
☐ Children at school (such as schoolmates)
☐ Children with developmental delays or disabilities
☐ Children with another vulnerability (please describe): _____
☐ Strangers or people they do not know well
☐ Neighbor(s)
☐ Adult(s)
☐ Children who are younger

B. Where did the behaviors you reported above occur (check all that apply):

☐ Home
☐ School/preschool/school bus
☐ Other (please describe):_____
☐ Neighbor's house
☐ Childcare provider
☐ Public setting (such as stores)
☐ Outside (such as a playground)

C. During any of the behaviors you reported above, did your child use coercion, such as force, threats, pressure, bribery, and/or trickery?

☐ No ☐ Yes (please describe):_____