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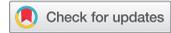
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Utilization of Telehealth for Problematic Sexual Behaviors for Children in Rural Communities: Engagement, Technical, and Clinical Considerations for Group Therapy

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ABSTRACT

Child mental health providers' usage of telehealth services has expanded exponentially since COVID-19, and applying evidence-based group services through telehealth has tremendous promise for reducing disparities in rural communities. Adopting abuse prevention treatments for problematic sexual behaviors (PSB) of youth is of particular interest due to the potential harm of untreated PSB. Group-based cognitive-behavioral therapy for PSB (PSB-CBT) has been found to reduce future PSB and has been adapted for telehealth. PSB-CBT group services via telehealth require specific safety, clinical, and technological considerations. This article provides a brief overview of PSB and rural communities, and considerations for group telehealth for PSB.

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Group therapy; telehealth; rural; problematic sexual behavior; children

Access to child mental health services is limited throughout the United States, particularly in rural areas (Elharake et al., 2023). One-fifth of the U.S. population lives in a rural area, and approximately 6.5 million of those individuals meet the criteria for mental health diagnoses (Morales et al., 2020; Substance Abuse and Mental Health Services Administration, 2017; United States Census Bureau, 2016). These rural communities face many obstacles, such as limited providers and rising hospital closures (Biggerstaff & Short, 2017; Weinzimmer et al., 2021). One avenue that has seen promise for reducing mental health service scarcity is telehealth. Since the coronavirus (COVID-19) pandemic, health-care across the United States has seen exponential growth in telehealth platforms and although literature is based on adult mental health services, recent research has found that telehealth can enhance child engagement and improve parental responsiveness (Svistova et al., 2022).

Recent findings indicate that one in six children in the United States has a diagnosed behavioral, mental, or developmental disorder, and approximately 80% of these children live in areas of the United States with mental health scarcity (Cummings et al., 2013; Ros DeMarize et al., 2021). Health statistics have found that 16–19% of children living in isolated to large rural areas have received developmental, behavioral, or mental health diagnoses compared to 15% of children living in

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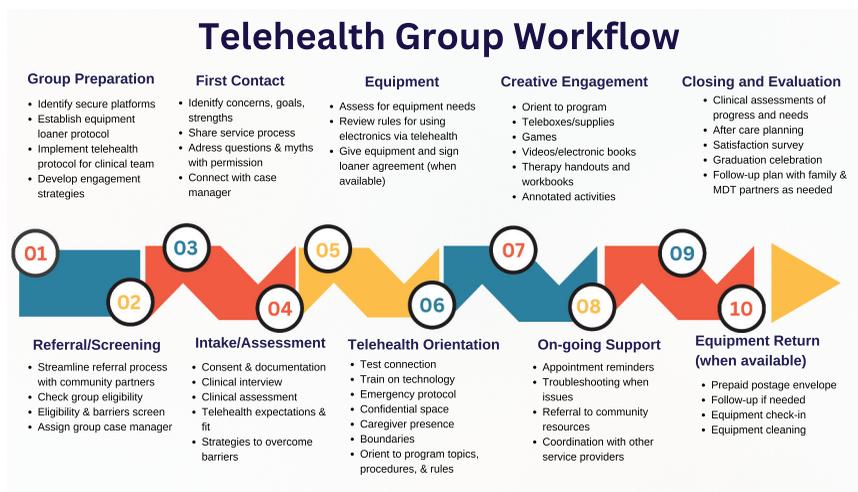


Figure 1. Telehealth group workflow.

urban areas (Robinson et al., 2017). Specific harmful behaviors, such as problematic sexual behaviors (PSB) in child populations, require early access to evidence-based services to prevent further harm and enhance child and family well-being (Dopp et al., 2017).

Research on group-based treatment programs, such as Problematic Sexual Behavior Cognitive-Behavioral Therapy (PSB-CBT), has revealed significant reductions in PSB among youth (Barry & Harris, 2019; Carpentier et al., 2006; Mori et al., 2025; Silovsky, Beasley, et al., 2018). Telehealth offers a notable opportunity to enhance access to treatment for PSB, particularly for rural, underserved communities. Due to engagement and safety factors, special considerations are required when translating and providing group-based EBTs for PSB of youth in the telehealth platform. This conceptual article provides an overview of the current literature on telehealth and group services for PSB, key clinical and technical considerations, and recommendations that inform assessment, treatment, and other factors that can assist providers in developing best practices for group telehealth services designed for children who have engaged in PSB (see Figure 1).

Telehealth Practices & Effectiveness for Group Therapy

Telehealth is a broad term encompassing various healthcare delivery methods, such as synchronous video conferencing and remote patient monitoring (Cain et al., 2016; Villalobos et al., 2023). Following COVID-19 restrictions, healthcare providers adopted telehealth at an unprecedented pace. A national sample of 2,169 licensed psychologists reported up to 80% of their clinical work was provided via telehealth during the height of the pandemic, compared to 7% before (Gerton et al., 2023; Pierce et al., 2021). Similarly, Patel et al. (2021) reported during COVID-19, approximately 30% of 16.7 million individuals engaged in outpatient healthcare visits were provided via telemedicine. Group therapy has seen rapid expansion to telehealth platforms. Group therapy using telehealth is not only feasible but also demonstrates low attrition rates and positive outcomes, even for

populations with significant mental health concerns, such as rural residents (Puspitasari et al., 2021).

While telehealth guidelines for adult populations has a longer history of research, the standards for pediatric mental health care using telehealth-delivered evidence-based practices have recently gained momentum. Research has found telehealth is as effective as in-person services for many behavioral and mental health diagnoses among children, such as generalized anxiety and post-traumatic stress disorder (McGrath et al., 2011; Racine et al., 2020). Telehealth-delivered EBTs, such as Parent-Child Interactive Therapy (PCIT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), have been found to have positive outcomes (Nicasio et al., 2022; Ros DeMarize et al., 2021). For example, Stewart et al. (2020) found that 96.8% of children who completed TF-CBT via telehealth no longer met PTSD criteria and reported high patient satisfaction rates. Despite these positive outcomes, research is still lacking regarding utilizing telehealth groups overall and specifically for problematic sexual behaviors in youth.

Rural Health Disparities

Social determinants of health factors must be considered when supporting families in rural communities. Rural populations are reported to have more children per household, higher unemployment, and higher rates of poor and uninsured residents than urban populations (Hart et al., 2005). Some literature finds that rural communities report higher mental health concerns, such as anxiety and suicidality, compared to urban areas (Eberhardt & Pamuk, 2004; Gonzalez & Brossart, 2015). Lack of services is a grave concern, with research showing that up to 50–80% of all rural United States counties do not have access to a psychiatrist or psychologist (Jensen et al., 2020; Morales et al., 2020). Past attempts to reduce health disparities in rural communities relied on economic incentives (e.g., public student loan forgiveness) to recruit health professionals (Health Resources and Services Administration, 2019; Morales et al., 2020). Unfortunately, provider retention rates over time are abysmal and perpetuate challenges in the continuity of care for many rural patients (Morales et al., 2020). This lack of adequate providers, combined with substantial barriers to treatment, creates an uphill battle for those aiming to reduce mental health disparities in rural communities.

Barriers to Mental Health Treatment

In addition to the limited availability of behavioral health services, rural residents face other systemic barriers to accessing care. Distance to services, inadequate transportation and childcare, and financial constraints are reported barriers for many rural families (Alegri´a et al., 2010; Kapke & Gerdes, 2016; Nicasio et al., 2022). Rural residents are affected by stigma (public and self-directed) and limited mental health literacy more than their urban counterparts (Cheesmond et al., 2019; Morales et al., 2020; Smalley et al., 2012). However, telehealth is a promising avenue for tackling many systemic barriers that underserved communities face when accessing care. Weinzimmer et al. (2021) found that although internet access was less available to rural populations, they had significantly more interest in telehealth than urban populations. Stewart et al. (2020) found that dropout rates fell to 11.4% when families engaged in telehealth treatment. Frye et al. (2022) reported families in

telehealth services saved on average, 132.20 miles traveled and \$22.42 per session. Thus, compared to traditional psychotherapy, telehealth services can enhance equitable care for rural residents (Madigan et al., 2021). Group-based telehealth is ideal, given its ability to reach more families, improve social connections, reduce isolation and stigma, and reduce the burden on providers. Despite telehealth's perceived benefits, concerns regarding its implementation and ability to produce outcomes similar to in-person psychological services remain.

Preventing Harm: Addressing Problematic Sexual Behaviors of Youth

Sexual behaviors of youth exist on a continuum of behaviors ranging from developmentally appropriate to outside what is considered acceptable by societal standard, and to problematic, harmful, and illegal sexual behaviors (Association for the Treatment and Prevention of Sexual Abusers [ATSA], 2023; Swisher et al., 2008; Theimer et al., 2023). The term “problematic sexual behavior” (PSB) does not refer to a diagnosable psychological disorder but instead is a clinically concerning pattern of behaviors that may be associated with trauma, disruptive behaviors, and developmental factors (ATSA, 2023). PSBs can include behaviors that involve showing, touching, or looking at sexual body parts, self-focused sexual behaviors, acts that involve coercion, force, or aggression, and the behaviors may occur in person or online/on social media (Allen, 2023; Munday et al., 2021).

Population-level prevalence rates are difficult to quantify due to limited measurement options and no specific agency charged with tracking PSB broadly. When examining illegal sexual behavior, children under 18 represented up to one-third of all sexual assault arrests in the US (Finkelhor et al., 2009). When examining Children's Advocacy Center (CAC) data across North America, the National Children's Alliance (NCA) found that around 20–25% of all cases involved youth who have acted out on another child (National Children's Alliance [NCA], 2021). A recent review of multiple sources in the United Kingdom (UK) concluded that about one-third of child sexual abuse is committed by another youth (NSPCC, 2024). Prevalence rates increase when youth and caregivers are directly surveyed, rather than relying on agency statistics. In a national representative sample, over 70% of sexual assault incidents were reported to have been committed by other youths (Gewirtz-Meydan & Finkelhor, 2020). Thus, addressing PSB in youth is an important public health target to prevent sexual harm (Russell et al., 2025).

Details regarding the professional practices of mental health professionals and agencies addressing PSB of youth is beyond the scope of this manuscript. Guiding principles, standards of care, qualifications, and ethical considerations are provided by the Association for the Prevention and Treatment of Sexual Abuse (ATSA) for serving children (ATSA, 2023) and adolescents (ATSA, 2017) as well as provided on the website of the National Center on the Sexual Behavior of Youth (<https://ncsby.org>).

Evidence-Based Group Treatment for PSB

Treatment outcome research for youth with PSB have suggested that quality EBPs are short-term, community-based, and directly involve parents/caregivers (Letourneau et al., 2013; Pritchard et al., 2025; St. Amand et al., 2008). Two treatment models for youth with PSB have been identified as having scientific support (i.e., randomized trial evidence):

Problematic Sexual Behavior-Cognitive Behavioral Therapy™ Treatment Program (PSB-CBT™) and Multi-Systemic Therapy-Problematic Sexual Behavior (MST-PSB) (Dopp et al., 2015). MST-PSB has demonstrated both short-term and long-term (24.9 years) positive outcomes with adolescents with PSB (ages 10 to 17; Borduin et al., 1990, 2009, 2021; Letourneau et al., 2009, 2013). MST-PSB is an intensive home-based treatment that addresses multiple determinants of serious antisocial behavior in youth; it was designed for youth with significant delinquent histories who warrant a high level of treatment intensity. Notably, parent practices mediate MST outcomes (Henggeler et al., 2009).

The PSB-CBT model is a family-oriented, cognitive-behavioral treatment group intervention model designed to eliminate PSBs and related trauma and behavior symptoms, reduce juvenile justice involvement, and improve prosocial behavior and well-being in youth while reducing stress and enhancing skills in caregivers (Carpentier et al., 2006; Theimer et al., 2023). Ten-year follow-up with preteen youth randomized to PSB-CBT™ found recidivism rates comparable to youth with no history of PSB (2–3%) and significantly lower than the randomized comparison play therapy group condition (10%; Carpentier et al., 2006). This treatment has been classified as effective on the OJJDP Model Programs Guide (California Evidence-Based Clearinghouse for Child Welfare, 2015; Hanson et al., 2009). A multi-site study implementing PSB-CBT found a large effect size for the reduction of PSB ($t(126) = 11.69, p < .001, d = 2.08$) (Silovsky, Beasley, et al., 2018; Silovsky, Hunter, et al., 2018), as well as gains in knowledge, skills, quality of relationships, family communication, and overall behavior (Shields et al., 2018). Further, PSB-CBT™ is cost-effective in addressing PSB and general behavior problems (Munday et al., 2020), with noted positive impact on the community (Munday et al., 2020).

The PSB-CBT open-format group treatment has concurrent child and caregiver groups and multi-family group experiences. Group therapy can destigmatize treatment, which is particularly important for families involved in PSB services (Shields et al., 2018). Through PSB-CBT group therapy, children directly address their PSB, gain interpersonal skills, develop prosocial relationships, practice skills, and receive feedback and support from their peers, caregivers, and the clinicians (Shields et al., 2018; Silovsky et al., 2011). Similarly, Shields et al. (2018) qualitative study found caregivers engaged in PSB-CBT groups reported reduced feelings of stigma, shame, and isolation, and gained from the interpersonal connections. Given the numerous benefits associated with the PSB-CBT group approach, clinicians are encouraged to use a group modality to support families, especially those who may be isolated due to both the taboo nature of PSB and the geographic isolation associated with living in rural areas. A family-therapy version of PSB-CBT can be provided when that modality is needed for the family.

Behavioral health agencies and CACs have begun to address rural disparities in services for PSB of youth through thoughtful adaptations of PSB-CBT groups through telehealth practices. Successful application of telehealth group therapy across North Dakota has improved access to care for PSB-CBT. Ongoing group services have been provided to youth across the state for over 4 years, most of whom otherwise would not have access to services (P. Condol & N. Herting, personal communication, September 27, 2023). PSB-CBT groups have been successfully implemented via telehealth through other programs in Chicago, Philadelphia, and Atlanta (<https://ncsby.org>). While organizations like the American Telemedicine Association (Turvey et al., 2013) have provided general guidelines for telehealth services, unique considerations, and guidelines are needed for PSB telehealth

treatment. The following section provides tailored guidelines for implementing telehealth group services to address PSB of youth, family engagement, strategies for successful implementation, and technical considerations.

Engagement Considerations for Telehealth PSB Group in Rural Communities

Past research has found that up to 80% of families engaged in child therapy drop out prematurely (De Haan et al., 2013; Gombly, 2000). Due to the taboo nature of PSB, clinicians may encounter greater challenges related to enhancing the motivation of caregivers and youth for PSB treatment attendance and participation (Shields et al., 2018). Families may present with hesitancy to engage in PSB services for a variety of reasons, such as stigma, disbelief, holding myths about PSB of youth, impact of past traumas as well as other mental health barriers such as past negative mental health service experience, history of discrimination, fear of system's responses, lack of telehealth usage, or poor mental health literacy (Borduin et al., 2009; Shields et al., 2018; Yoder & Ruch, 2015). Racial, ethnic, and socio-economic disparities in responses to PSB include reporting, access to services, substantiation, and legal response (Fix et al., 2023; Munday et al., 2021). Social service agencies or the court system may require PSB treatment. Families mandated to attend treatment can struggle to engage in services due to various issues, such as skepticism and frustration from a lack of communication among agencies (e.g., law enforcement, child protective services) (Shields et al., 2018). It is important to note that while initial motivation for services may be low for families, the group services provision of support, connections, effective skills, and positive testimonials shared by other families can enhance the new family's motivation and engagement in PSB-CBT services (Shields et al., 2020).

Strategies to Enhance Engagement in Group Telehealth Treatment for PSB of Youth

Implementation of engagement strategies begins at the first point of contact. Given the range of family concerns, staff should possess clinical engagement skills and knowledge about PSB of youth and evidence-based services at the initial call. Thus, it is recommended to have a designated PSB treatment coordinator for telehealth services who can quickly connect with families, listen to their stories, answer any logistical, PSB, and treatment questions, and provide support as they begin treatment. The coordinator can explore each family's understanding of the behavior, level of motivation for services, barriers to services, and goals for treatment to create clear reasons for participation. Caregivers can benefit from psychoeducation resources outlining PSB therapy, common questions, and any safety guidelines families can follow before beginning treatment. The coordinator can share success stories, inspire hope, and use active listening to explore the family's goals for treatment and any potential barriers regarding using telehealth.

The therapeutic alliance is often regarded as one of the best predictors of outcomes in mental health services (Weinberg, 2020). Researchers have found that a clinician's ability to build rapport with the family involved in PSB treatment is crucial for family engagement (Yoder & Ruch, 2015). Shields et al. (2018) found that caregivers identified positive clinician qualities such as being "nonjudgmental" and "caring" as impactful factors in their engagement in PSB-CBT services. Additionally, the therapeutic alliance is an important part of the

group therapy experience, as it can enhance family engagement by reducing isolation and stigma (Shields et al., 2020). In their qualitative research, one caregiver stated, “. . . the support for me was good to be there with them because we all shared a common bond. We were there to get help for our children (Shields et al., 2020, p. 5).” Group therapy directly impacts isolation and shame through shared understanding, facilitated healing and engagement, peer support, and opportunities for natural testimonies from families near graduation who can share progress and instill hope in the newly involved families.

In telehealth, clinicians should incorporate strategies to enhance the connection among caregivers and youth group members. Connections among members can be facilitated through deliberate efforts to experience commonalities and share struggles and successes with one another. Power points, whiteboard and annotated activities, reinforcement charts, and interactive games and videos can all strengthen engagement and treatment acceptability. When implementing activities, clinicians should encourage active participation and open conversations throughout the materials rather than treating the group as a “class.” Group rules for expected participation during telehealth activities should be discussed during each family orientation and included in treatment contracts. Specifically, families should be informed that telehealth groups operate similarly to in-person groups, limiting any distractions that would prevent attentiveness (e.g., driving, texting) during group time. By eliminating distractions, the focus becomes on group members’ support and connectedness. Such group cohesion is key to successful group therapy (Yalom & Leszcz, 2020).

Lastly, implementing “teleboxes” to provide supplies needed for services can increase engagement in PSB-CBT. Materials for the PSB telehealth group can include treatment workbooks for the caregiver and child, assessment tools, writing utensils, and craft materials. Additional technology needs may have been identified in the orientation session that can be included, such as headphones, white noise machines, and device protection cases. The screening may have identified other support needs for successful engagement in group telehealth services. Items such as fidgets, stress balls, stickers, and other materials can help the youth or caregivers maintain focus and reduce distractions while in a telehealth group. It will be important to discuss what items the child would do best within group sessions and how to manage the supplies. Utilizing teleboxes can facilitate keeping track of each week’s handouts and homework materials. Identifying a safe space to store the telebox can be integrated into the orientation session with indications not to be used outside of therapy to ensure supplies last throughout treatment.

Culturally Responsive Care in Group Settings

The PSB-CBT group treatment manual is not a cookbook that is implemented as prescribed, but rather, the treatment is implemented by understanding the core concepts and methods with an approach to honoring family values, strengths, and resiliency through culturally responsive approaches. Addressing PSB of youth involves some of the most value-laden and sensitive topics for families: sexual behavior, sex education, relationships, and parenting practices. Culturally responsive care requires active listening, trust, openness, awareness, humility, understanding, sensitivity to history and trauma, and curiosity without judgment (Silovsky et al., 2024). To facilitate culturally responsive care for American Indian families, *Restoring the Sacred Circle Toolkit for American Indian and Alaska Native Tribes* was recently published, providing multiple resources on traditional views of sex and sexual behavior,

collective wisdom from elders, principles for working with Tribes with fact sheets, podcasts, and other resources (Kelley et al., 2024). A second toolkit for cultural considerations when providing PSB-CBT to Latino youth and their families (Mürrle et al., 2024) addresses cultural values, language, religion and spirituality, culture-bound syndromes, acculturation, enculturation, and related subjects. The complexities of rural communities' rich cultural history, values, resilience, historical trauma, discrimination, and hardships are important considerations for developing and implementing culturally responsive care for PSB.

Family Needs and Logistical Barriers to Group Treatment

Mental health service shortages are exacerbated by the rural environments, climate, and stigma, which result in barriers to care such as transportation, distance, long waitlists, minimal health coverage, and hesitancy to seek services (Gonzalez & Brossart, 2015). Clinicians working with rural communities must be attuned to these barriers and identify them to meet the family where they are before treatment, thereby reducing premature dropout. Agencies may develop semi-structured needs assessments to identify potential barriers, collaborate with the family to problem-solve, and create strategies to navigate identified barriers. By implementing an assessment system before treatment, clinicians can advocate for client needs and coordinate with potential referral sources (e.g., Medicaid, housing) that can reduce client attrition rates.

Clinician Telehealth Competency in Group Settings

Notably, competent and ethical application of telehealth group services requires education, training, and guidance on effectively planning, implementing, and managing telehealth groups. Clinicians can build on their foundation of in-person group clinical skills (Shields et al., 2020) to address telehealth's unique ethical issues (e.g., consents, privacy protections), technology issues (e.g., controls, safety), and implementation of group therapeutic strategies in an engaging manner with children and their caregivers (Chang et al., 2016). Group programs are best implemented by a collaborative team that can assess their comfort with directing a telehealth group, plan how to troubleshoot any technical difficulties, and prevent therapeutic obstacles during the sessions. Qualitative research has found that caregivers and youth have suggested that clinicians provide clear session materials and create a nonjudgmental environment to improve the group experience (Shields et al., 2018, 2020). Descriptive research focused on rural communities' satisfaction with telehealth services reported clinicians' technology and group topic knowledge enhanced the group process (Doorenbos et al., 2010). Considering session durations, monitoring group participation, and adopting break times may all be areas where a clear protocol can be established to ensure the groups run smoothly. By adequately training and planning the necessary adaptations to make telehealth groups engaging for families, clinicians will promote the same equitable practices seen in in-person services.

Technical Considerations for Telehealth PSB Group in Rural Communities

Before the family joins the group, the coordinator should assess the family's access (e.g., internet devices, WIFI access), experience, and comfort level, as many families will likely

vary in their access and technology literacy. Agreeing to participate in telehealth services does not translate into being tech-savvy. In rural areas, telehealth may be the only option for families. However, providers should not assume that all families participating in services will be able to use technology seamlessly without practice and should be assessed before orientation. Additionally, rural families may not have access to preferred devices (e.g., laptop/tablet vs. cell phone). PSB-CBT telehealth group requires one device per participant; therefore, clinicians working in rural and underserved communities should explore implementing an equipment loaner program to reduce access barriers. Through these programs, clinicians can loan out data-enabled devices that can safely provide internet services necessary to participate in a telehealth group. Should families request loaned devices, caregivers should sign equipment agreements, and coordinators should set up the device (e.g., downloading tele-platform) and provide necessary device information (e.g., user ID) before loaning the device. During a “tele-orientation,” the coordinator and family engage in a test call to troubleshoot device issues. Plans for responding to inappropriate device use, noncompliance with group etiquette, and safely storing devices should all be discussed during the test call. By providing devices, agencies can reduce the financial strain on families and continue facilitating positive service engagement.

During the orientation, providers can identify any technological errors, practice inputting passcodes, and confirming mics and audio are functioning as needed for cohesiveness in group sessions. Clinicians should establish clear rules for families regarding using chat and annotate features, having cameras on throughout the group, and screen-sharing privileges. Additionally, the clinician should collaborate with the family to create an emergency plan, including consent for emergency contacts. By incorporating these discussions during the tele-orientation, the clinician can troubleshoot any barriers to identifying and creating safe, confidential spaces to participate in group therapy. Lastly, agencies are encouraged to create a telehealth “tip sheet” with step-by-step visual instructions on accessing the group and group materials before the first session.

Note that youth receiving PSB treatment through telehealth have unique safety considerations compared to the general public. Access to sexually explicit materials and using electronics for communication (e.g., “sexting”) is of particular concern for youth with PSB. Notably, about a third of youth in a national sample endorsed viewing pornography at least once before being a teenager (Astle et al., 2022). For telehealth groups specifically, electronic and online safety is especially important to review and establish through a detailed clinical assessment and interview. Clear protocols and procedures are necessary to enhance safety practices and promote safety for the youth and the community. If technology is provided, protocols and procedures regarding loaned devices should include limiting access to technology outside of the telehealth platform.

Group Specific Treatment Privacy and Confidentiality

Families’ understanding of privacy while engaging in telegroups will likely vary. During orientation, children and their caregivers should be informed of privacy limitations when using telehealth services. Clinicians conducting group therapy cannot assume that confidentiality can be strictly kept online as it is in clinical offices; therefore, therapists must communicate clearly that confidentiality may be more challenging to promote when using telehealth platforms (Weinberg, 2020). Modalities like PSB-CBT utilize home activities for

youth and their caregivers to practice skills and enhance knowledge related to PSB. During orientation, clinicians are encouraged to discuss privacy limitations (e.g., lack of private living spaces) and strategize ways to secure the youth's sensitive treatment information. Families should be informed that recording the sessions is prohibited and requires a signed agreement that they will keep fellow group members' shared information private. Further, clinicians must determine what telehealth platforms meet their organization's Health Insurance Portability and Accountability Act (HIPAA) privacy statutes (e.g., professional Zoom with BAA). Clinicians should implement authorization requirements for recording, chat features, and utilize waiting rooms to monitor and ensure individuals can only attend groups if permitted.

Access and Connectivity Barriers for Group Therapy

Research shows that even after COVID-19, reliable forms of internet connection are not readily available for approximately 7–10% of U.S. individuals due to factors such as economic hardships or lack of connectivity due to being in rural areas (Ros DeMarize et al., 2021). Providers should identify device availability and the family's internet connectivity before treatment engagement (Nicasio et al., 2022), as well as the number of available devices, given that PSB-CBT groups utilize separate caregiver and child groups and are conducted simultaneously. If families do not have the required number of devices, preplanned procedures should be implemented, including data-enabled devices and accessories (e.g., headphones, webcam). If, during orientation, it is discovered the family does not have adequate Wi-Fi capabilities or data, it will be critical to identify locations (e.g., churches, schools) that have confidential spaces with Wi-Fi capabilities available that they may utilize for the group. If the family must utilize a location outside the home (e.g., public library), clinicians should re-review the limits of confidentiality. Consider establishing MOUs with local agencies that can provide private space and internet access for services. Ideally, these barriers should be addressed during the needs assessment process and should be monitored through treatment.

Clinical Decision-Making for PSB and Telehealth Group Appropriateness in Rural Communities

Clinical assessment is a necessary and valuable component of addressing the needs of youth with PSB and their families. A task force commissioned by the Association for the Treatment and Prevention of Sexual Abuse (ATSA, 2023) recently published updated guidelines related to the assessment of PSB and encourages providers to consider factors such as placement, youth safety, negative social impact, educational problems, family and community support, abuse history, and any cognitive or learning disabilities. Additionally, creating a clinical decision-making process will aid in treatment planning to address prioritized behavioral health needs, given the complexities of presentations (Allen, 2023).

Many children with PSB have comorbid mental health concerns, such as externalizing behaviors (e.g., hyperactivity, aggression) and internalizing behaviors (e.g., anxiety, depression), as well as developmental concerns (Ros DeMarize et al., 2021). Virtual learning research has found the child's environment may be an obstacle in facilitating positive group behavior online, therefore discussing practical and pragmatic rules are essential to

active engagement in group services (Manea & Gări-Neguț, 2021). Providers should determine their level of comfortability in addressing these concerns as they arise in telehealth sessions. A common criticism of co-mingling youth behavior problems in group-based approaches is the opportunity for learning problematic behavior (Dishion et al., 1999). Key to preventing negative peer influence during group PSB-CBT is the focus on all youths' capacity to learn and apply positive decision-making, creating a group culture reinforcing healthy decisions and relationships, and having behavioral management systems in place to prevent and immediately stop misbehavior. In session, behavioral control of the group dynamic is necessary for establishing and maintaining a group culture of prosocial behavior. Clinicians can routinely use self-report measures to gauge internalizing behaviors, such as depressive symptoms, or request weekly parent reports of the youth's behaviors to gauge behaviors that are more difficult to gauge through telehealth. Providers should discuss coping strategies children may use before and throughout treatment.

Clinicians should apply a developmentally responsive approach to group implementation to best support the group effectiveness and bolster children's skill development. This may include observational or behavioral assessments prior to group to determine group appropriateness. The PSB-CBT model encourages clinicians to divide groups based on age/developmental level (e.g., 7–9-year-olds, 10–12-year-olds) due to different types of developmentally appropriate sexual health information that may be shared in groups. School-aged children have developing attention spans and may require more breaks and activities (e.g., PowerPoint slides) to engage in materials compared to adolescents. Clinicians should consider the typical “group norms” that may vary between each developmental stage and how they plan to approach obstacles to group therapy engagement. Behavioral techniques like reward systems and scheduled breaks help maintain cohesive group sessions.

Even if children display behavioral problems, telehealth may be the only option for youth based on their location or presenting barriers. Due to this, clinicians should be prepared to plan strategies to enhance treatment engagement for youth and caregivers in a telehealth group. Given the unique need for flexibility in telehealth groups, clinicians need to reserve time before beginning the groups to think of how they can be creative in implementing each module in an engaging manner. However, if, through the clinical decision process, clinicians determine PSB-CBT is inappropriate based on client history, providing services that match the family's needs or referring to a provider or agency that can provide the recommended treatment is recommended.

Safety Concerns and Electronic/Online Sexual Behavior Histories

Youth referred to treatment for PSB may have a history of electronic/online sexual behaviors (EOSB), such as excessive pornography usage or sending/receiving sexually explicit online messages. Thus, online safety and security are critical in providing services for PSB via telehealth. Regarding the group format for PSB-CBT, it is recommended that clinicians discuss how they plan to review the necessary safeguards to ensure electronic safety before the group orientation. Strategies during group sessions may include requiring the youth to keep their camera on and their face in view, having the youth sit far enough back that you can see their hands and body, requesting that the child be in a space with no other devices, and scheduling check-ins by the caregiver throughout the group. Caregivers can be taught how to examine the

internet history, implement security measures (e.g., blocking websites) on all devices in the home that youth can access. In some cases, youth with a significant EOSB history should receive locked-down devices from the treatment agency to reduce the risk of future ESOB.

Discussion

Rural and underserved communities face persistent barriers to mental health treatment, and telehealth group services offer a promising means to reduce disparities for youth with problematic sexual behavior (PSB) and their families (Gonzalez & Brossart, 2015; Smalley et al., 2012). Implementing PSB-CBT via telehealth requires attention to stigma, shame, and community isolation. The adaptations proposed here aim to guide culturally responsive, effective practice, and inform future research. PSB-CBT reduces recidivism, externalizing and internalizing symptoms, caregiver stress, and enhances caregiver knowledge, skills, and community safety (Barry & Harris, 2019; Carpentier et al., 2006; Mori et al., 2025; Munday et al., 2020; Shields et al., 2018, Shields et al. 2020; Silovsky, Beasley, et al., 2018; Silovsky, Hunter, et al., 2018). Outcomes research is recommended to examine comparative benefits of telehealth PSB-CBT group therapy services on key symptoms (e.g., PSB, externalizing behaviors, internalizing symptoms), protective factors, program attrition, retention, service access, and engagement is needed. Additionally, qualitative research could explore nuanced factors that may impede their engagement with treatment services (Shields et al., 2018). Such research can help improve our understanding of the unique barriers that rural communities face and support the development of updated guidelines for providers working with youth who have engaged in PSB.

Collaboration with agencies beyond behavioral health is essential. Cases often involve multiple agencies, such as law enforcement, social services, and children's advocacy centers, which benefit from multidisciplinary teams (MDTs) to coordinate identification, referral, and treatment planning (Kelley et al., 2019; Munday et al., 2021; NCA, 2018; Taylor et al., 2021). MDTs can present a united voice for recommendations for families and promote and enhance communication across agencies (NCA, 2018; Taylor et al., 2021). MDTs can provide guidance and problem-solving strategies related to identifying confidential spaces for treatment, supporting group approach to treatment, navigating equipment/internet issues, and monitoring family attendance in services. Most importantly, clinicians can promote the least restrictive treatment methods by integrating families into the MDT model through children's advocacy centers (Taylor et al., 2021).

Before telehealth options, group-based treatment in rural communities raised concerns about confidentiality in small communities. Extending the geographic area of families involved by using telehealth could help address this concern by reducing the likelihood that families in the group know each other. Small agencies may not have the capacity to support the number of clinical personnel required for group implementation. Specifically, the PSB-CBT National Training and Technical Assistance Team recommends having at least two providers for a child's group and one, preferably two, for a caregiver group. This can also be achieved by multiple sites joining together to provide telehealth group services. When family-based services are needed, MST-PSB for older youth has demonstrated both short-term and long-term (24.9 years) positive outcomes with youth with PSB (ages 10 to 17;

Borduin et al., 1990, 2009, 2021; Letourneau et al., 2009, 2013). Further research on family-based PSB-CBT (Jones et al., 2023) and Phase-based Treatment (Allen et al., 2018) outcomes and adaptations for telehealth will enhance accessibility for younger youth.

In summary, telehealth group treatment for PSB of youth has great potential for enhancing community safety, reducing risk of harm, and addressing disparities in access to child mental health services, especially in rural communities. Successful implementation of group telehealth requires careful consideration of clinical, technological, and engagement strategies. The feasibility of PSB-CBT group therapy has been supported by implementation in North Dakota (citation withheld for anonymity of review). While promising, further research on implementation of PSB-CBT and similar programs is needed to examine engagement, barriers, and outcomes.

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