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Childhood Sexual Abuse, Current Prevention Programs and Recommendations for Change

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CHILDHOOD SEXUAL ABUSE, CURRENT PREVENTION PROGRAMS AND
RECCOMMENDATIONS FOR CHANGE

by

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TABLE OF CONTENTS

INTRODUCTION

Childhood sexual abuse (CSA) is an international epidemic (Barron & Topping, 2013) defined as any sexual activity between an individual before the age of legal consent and a more powerful adult or a considerably older child, in which the younger, weaker child is used for a sexual or erotic function (Reid, Reddock, & Nickenig, 2014) . CSA is traditionally stereotyped as sexual touching or penetration, however, there are many other acts that can be included in this category. Intrusion, such as continuously walking in on a minor while they are changing or showering with the intent to see them naked is considered a form of sexual abuse. Child prostitution or involvement in pornography is currently a major concern with the widespread use and misuse of the internet. Voyeurism or exposing oneself to a child, showing sexually illicit material to a child and attempting or threatening sexual abuse with contact are all considered to be forms of sexual abuse (Chen, Fortson, & Tseng, 2012).

Childhood sexual abuse is one most traumatic events that a child can experience and detrimental consequences are often long-lasting (Chen et al., 2012). Negative consequences for children may include physical changes such as an alteration in brain structure and stress hormone regulation (Tutty, 2014). For youth, CSA is a significant predictor of school failure.. Those who were abused as children also have an increased risk of being sexually assaulted in later in life. Adults and adolescents with a history of sexual abuse are also more likely to experience suicidal ideation (Tutty, 2014), diminished self-esteem, substance abuse, anxiety and depressive disorders, posttraumatic stress disorder (Barron & Topping, 2013), anger and aggression, dissociation, sexual difficulties, sexually transmitted infections, and self-harming behaviors (Pulido et al., 2015). Although there are many consequences of childhood sexual abuse, how it

affects the child across the lifespan depends on various features of the abuse including: the degree and duration of sexual abuse, the age when abuse first started, the relationship between the abuser and the victim, the extent that violence or a threat of violence was imposed, how long it takes disclosure to occur, the degree of family support after disclosure, the quality of after-care, and the meaning ascribed to the victimization by the child (Walsh & Brandon, 2012).

In the US, one in ten children report being sexually victimized, for a total of 62,936 child sexual abuse cases in 2012. Due to the sensitivity and reluctance to report sexual abuse, this number may not adequately reflect the extent of the problem (Barron & Topping, 2013; Pulido, Dauber, Tully, Hamilton, & Smith, 2015). Many sexually abused children do not come forward until adulthood, in which case, 15%-32% women and 5%-16% of men report being abused as children. A significant amount of these adults claim the abuse might not have occurred if they had more knowledge of what sexual abuse was and about available intervention resources (Daigneault, Herbert, McDuff & Fappier, 2012).

Childhood sexual abuse victims are both boys and girls of all ages. Some victims are wealthy, while others are poor. There is no specific ethnicity, religion, or demographic location in which CSA occurs exclusively (Kenny & Wertele, 2012). However, research states that there are certain groups that are more at risk for childhood sexual abuse than others. Gender plays a factor in CSA, with more females being targeted for victimization than males. Age is also a factor, with victimization occurring most frequently between the ages of 7 and 12. Parents with substance abuse issues and violent households are also more likely to involve sexual abuse, perhaps because they are less committed or less able to stop abuse (Zeuthen & Hagelskjaer, 2013). Finally, individuals with developmental disabilities are especially at risk for becoming victims of sexual abuse. It is estimated that 39% to 68% of developmentally disabled girls, and

16% to 30% of developmentally disabled boys will experience some form of sexual abuse before their 18th birthday (Bowman, Scotti & Morris, 2010).

Although CSA is an uncomfortable topic for children and adults to discuss, it is an issue that needs addressing. Beyond psychological damage to children both in the short-term and long-term, it may also lead to long-lasting effects that lessen the likelihood of success in educational and occupational endeavors and predispose them to a criminal lifestyle. Effective programs not only help prevent sexual abuse, but also help encourage earlier disclosure of prior sexual abuse and lead to lower levels of victim self-blame (Daigneault et al., 2012).

Theoretical Overview and Literature Review

Hirschi's (1969) Social Bond theory is a common theory in explaining crime, but can also rationally apply to victimization. The theory states that every person is inherently driven to commit crime unless it can somehow be controlled. In the case of CSA victimization, it can also be assumed that all children are vulnerable to sexual victimization unless that vulnerability can be reduced through the means of intervention. There are four main components in the theory, attachment, commitment, involvement and belief that can be applied in order to strengthen a child's support system and help deter potential perpetration.

Attachment is defined by the theory as an emotional connection with others, with most influential attachment focusing on the parent-child relationship (Hirschi, 1969). Direct control can be enforced by caregivers who spend a great deal of time monitoring youth and guiding their actions. When an important relationship exists, like the one between a parents and their children or a teacher and a student, the caregiver may also have indirect control over the youth. Even in the absence of direct monitoring, if the youth cares about potentially disappointing the caregiver, they are likely to still take the caregiver's preference into account. If problematic behavior would

foreseeably jeopardize the relationship with those he or she cares about, risky circumstances are more likely to be avoided. When hazardous environments and situations are avoided, there may also be a lesser chance of victimization.

Chan & Chui (2013) related attachment to victimization concluding that low parental attachment can have a negative effect on a child's self-esteem, which may decrease the likelihood of using self-protective behaviors, thus leaving children more vulnerable to victimization. They also found that child victims scored lower on measures that assessed attachment and commitment to school when compared to non-victimized peers. In relating attachment to CSA victimization, strains on the parent-child relationship or a teacher-child relationship could been seen as parents or school personnel acting in a way that leaves children vulnerable for sexual victimization, such as not directly monitoring the child. When a child feels unprotected due to caregiver negligence, even if it is unintentional, the bonds of the relationship could weaken. Strains on the parent-child relationship could also come from children hiding victimization from their parents and attempting to deal with it on their own rather than seeking help because they do not feel comfortable disclosing abuse or they believe their parents will not protect them.

Other studies have found evidence that strong parental attachment is linked to increased verbal communication skills (Savage, 2014), which is one of the main techniques that help combat victimization. Strong parental attachment is also linked to less risk-taking behavior, which could directly affect the chances that victimization could occur. Additionally, a strong bond with parents is related to reduced levels of depression and healthier coping skills. Thus, strong bonds may serve as a protective factor in dealing with CSA aftercare.

Commitment is considered to be a rational choice to devote oneself to conformity (1969). If a school-based CSA program educates and involves parents in prevention strategies, parents and teachers are more likely to understand what they are risking by not taking deliberate precautions to protect their children as the program suggests. Thus, the program increases parents' and school personnel's commitment to child safety. Additionally, students, by learning about the cost of victimization and ways to avoid it, strengthen their commitment to actively avoiding problematic situations and reporting uncomfortable encounters to a trusted adult.

Involvement consists of participating in positive activities that take up time, thus if an individual is continually occupied in positive activities, it is believed that they are less likely to be involved in problematic situations (Hirschi, 1969). Involvement in a CSA program can be considered a positive way to spend time in that it teaches children, parents, and teachers skills regarding child safety that otherwise may not be discussed. Active involvement and exposure to the program can also help build a set of beliefs.

According to the theory, beliefs are ideas that have been internalized and are likely to guide behavior. Once children, parents and school personnel have internalized the main components of the program, they are more likely to behave in a ways that is guided by those components. For example, when children can correctly identify that they are being approached in a sexual manner, they are more likely to know from the program that the situation is unacceptable and a trusted adult must be told. CSA programs also challenge commonly held beliefs that are incorrect, such as only certain populations of children can be targeted or that sexual abuse is likely to be perpetrated by strangers.

PREVENTION STRATEGIES OVERVIEW

There are three main levels of prevention strategies, primary, secondary and tertiary prevention (Brantingham & Faust, 1976). Primary prevention is the broadest form of prevention and would be directed at either the conditions that lead to perpetration or victimization in the environment at large. An example of this would be offering education and support to a community before the sexual abuse knowingly occurs. Secondary prevention targets individuals or families that are shown to be at-risk for a certain type of offending or victimization. Such strategies would help alleviate problems and prevent escalation. Tertiary prevention focuses on those who have committed an offense or who have been victimized, in order to prevent recidivism or to reduce the likelihood of negative consequences from victimization.

Initially primary prevention strategies were proposed to universally target children in order to counter sexual victimization. Although research provides certain age ranges, genders and special populations that might be at a greater risk, sexual abuse could potentially happen to any child. Additionally, universal programs can be delivered without stigmatizing those who have an increased risk of victimization (Walsh, Zwi, Woolfender & Shlonsky, 2016). More recently researchers contend that including the children's families, professionals that work closely with children and in some cases, the community at large could have beneficial effects (Zeuthen & Hagelskjaer, 2013). According to research there are several components that are essential to creating a successful prevention program, especially determining risk, assessing needs and responding to those needs (Andrews & Bonta, 2010a), which is commonly referred to the risk-needs-responsivity (RNR) model. Although the majority of programs utilizing the RNR model direct their attention to meeting the needs of adult offenders, it has also been used to help rehabilitate juvenile offenders and is considered to be generalizable to many other areas of

prevention (Andrews & Bonta, 2010b; Brogan, Haney, Nemoyer & DeMatteo, 2015). Thus, for the purposes of this paper, the RNR model will be applied to preventing childhood sexual abuse victimization.

Those who are at risk for victimization are deemed eligible for services. Risk factors include characteristics of an individual and their situational circumstances that are linked to an increased risk of victimization (Andrews & Bonta, 2010a). Although all children are to some degree vulnerable to CSA victimization due to their physical and cognitive inferiority to adults and older children, certain children may be more at risk than others. According to research on CSA, the population at the highest risk of victimization would include children who are female, between the ages of 7 and 12, children in households that include violent adults or substance abuse, and children who are developmentally disabled. According to the risk principle, treatment services should be matched with the risk level of victimization. Thus, children that fall into the high risk category due to their gender, age, home environment or disability should receive more intensive services, whereas children who are at a lower risk for victimization require minimal intervention.

Prevention programs should not only consider risk, but protective factors as well (Andrews & Bonta, 2010a). Protective factors are individual characteristics and situational circumstances that are linked to a reduced odds for victimization. For instance, a strong parent-child bond can be considered a protective factor in that it may reduce the chances of initial or subsequent victimization. Thus, the reducing risk factors while utilizing and strengthening protective factors is likely to provide a more efficient strategy to combatting victimization.

Need refers to problematic circumstances and helps prevention programs determine what should be treated. When looking at offenders, need is often broken up into criminogenic needs

and non-criminogenic needs (Andrews & Bonta, 2010a). Criminogenic needs are needs that can be changed, such as antisocial attitudes, and with change, help reduce criminal activity. Criminogenic essentially help prevention programs to develop a target for change. These needs that are targeted for prevention and may also be applied to CSA victimization are attitudes, behavior, and circumstances pertaining to family, school and leisure activities (Brogan et al., 2015). Thus, if prevention programs can target these specific factors and are able to ensue change, there is likely to be a change in the levels of victimization as a result.

Non-criminogenic needs are considered less important targets because they typically do not lead to a direct change in the targeted behavior (Andrews & Bonta, 2010a). However, meeting non-criminogenic needs has been shown to affect the participant's motivation to participate in a program. Applying this idea to CSA programs, self-esteem is a factor that may not directly reduce victimization. But CSA programs involving components that help build self-esteem have shown greater success, perhaps due to the fact that helping a child feel competent and capable helps facilitate skill building (Brassard & Fiorvanti, 2015).

Responsivity is a programs response to how a program treats the target population (Andrews & Bonta, 2010a). There are two specific types of responsivity, general and specific. General responsivity includes incorporating therapeutic factors that are commonly regarded as an effective approach (Brogan et al., 2015). For example, a strong rapport between the facilitator and the participants generally leads to better participant outcomes. Other general effective strategies used in prevention programs include: modeling, positive reinforcement, role play and skill building. It is also important to modify risk-enhancing thoughts, emotions and actions and to continually practice new behavior alternatives that reduce the chances of victimization is risky situations.

Specific responsivity helps to match the prevention to specific participant characteristics such as their personal strengths, motivations, age or ethnicity (Andrews & Bonta, 2010a). For instance, program curriculum should vary by the age of the participant, using terms and application in a way that is appropriate for a child's cognitive maturity level. Additionally, programs should use role play scenarios that are applicable to the culture and immediate environment in which the child lives.

Research has concluded that the RNR model is successful at reducing criminal offending (Brogan et al., 2015). Studies that have assessed the RNR principles individually have confirmed the programs' assertions. It was concluded, programs that allocate more resources to high-risk individuals rather than low-risk showed a greater reduction in unwanted behaviors. Addressing needs directly related to the unwanted behavior rather than needs indirectly related also lead to greater reductions in the unwanted behavior. Additionally, utilizing cognitive-behavioral approaches lead to reductions in unwanted behavior, as suggested by the principle of general responsivity. Overall, it was found that programs that more closely adhered to the risk, need and responsivity principles, the more effective the program was at reducing unwanted behavior. Although victimization is not caused by any certain action by the victim, the RNR model can apply in order to reduce the actions and circumstances that increase the risk of CSA victimization.

Two other components that are important to look at when creating an effective prevention program are program integrity and modality. Modality refers to the number of dimensions that a program targets. It is well accepted in literature that multi-modal prevention approaches are more effective than interventions that focus on some specific component (Tuscano, Rubin, O'Brein, Coplan & Thomas, 2015). For instance, a program directed at preventing CSA through

educational videos is not likely to be as effective as a CSA program that also includes role playing and important information that children can take home and discuss with their family.

Program integrity is the degree that a particular curriculum is implemented as intended (Dane & Schneider, 1998). The two major components that contribute to program integrity (Hansen, Graham, Wolkenstein, & Rohrback, 1991). First is the quality of program delivery, which may vary greatly depending on the training adequacy, comfort level, communication skills, and the motivation of the facilitators. The second component is the reception of the intervention by the targeted population. Although it is difficult to ensure active participation in any program, interventions targeting children should include various ways in teaching curriculum and should meet for several shorter sessions in order to keep their interest. Also group activities that require active participation rather than passive learning help children better understand the information and increase the likelihood of knowledge recall (Durlack, Weissberg, & Pachan, 2010).

For youth, most interventions take place in the school setting (Dane & Schneider, 1998). However, successful implementation depends on how useful the staff feels the program is and how the intervention fits into an already full academic schedule. Therefore training should enlighten staff on the seriousness of CSA and instill a passion for protecting students. Training should also include videos and/or manuals with clear descriptions of curriculum and activities to implement. Besides training, supervision is also important to program integrity, in order to keep facilitators in line with the program expectations.

Currently, like majority of other youth interventions, most sexual abuse prevention programs are organized around a school setting. These school-based programs attempt to teach children basic skills in identifying abuse, fleeing abuse and disclosing abuse to trusted adults.

Some programs include a parental component, which either includes sending home CSA related information that parents can review with their children or teaching parents about CSA directly. Fewer programs involve a school personnel component, which includes training for school staff regarding how to talk to children about abuse and identify signs of abuse. Very few programs contain the school-based, parental, and school personnel component. However a multi-modal approach would likely be the most effective way to address childhood sexual abuse because it would strengthen the bonds between children and their two major caregiving allies. It would also allow children, parents and teachers in invest a mutual commitment towards safety and prevention.

CHILD-BASED COMPONENTS

As previously stated, most sexual abuse prevention programs target children and often take place in a school setting (Rehingold, Zajack & Patton, 2012; Tutty, 2014). Internationally this setting is believed to be an effective approach to sharing information on the subject. School-based sexual abuse prevention programs gained popularity in the United States during the mid1970's after the passing of the Child Abuse Prevention and Treatment Act (Walsh et al., 2016).

Child-focused programs seek to decrease the vulnerability of children as victims and arm them with knowledge that will help them avoid initial or subsequent sexual victimization (Chen et al., 2012). Such interventions universally target three major concepts. First, it is necessary that children understand body ownership and what parts are considered private parts. They are taught about the touch continuum, which ranges from good touching, to confusing or uncomfortable touching to bad touching. There is also a need to discuss the difference between which secrets are acceptable to keep and which are not. Children should learn how to identify abusive interactions, refuse uncomfortable touching, get out of the situation safely and tell a trusted adult. The final objective is to decrease an abused child's feelings of responsibility and guilt and refer them to local counseling or medical resources as needed.

Most CSA models that directly target children utilize either information-based training (IBT) or behavioral skills training (BST). IBT programs provide information to children in a lecture based format. This may include educational videos, theatrical presentations or plays, age appropriate reading materials, or activity books that encourage discussion. BST programs provide comparable information but includes an active rather than a passive component. In BST programs children are asked to rehearse self-protection skills such as refusal, how to safely flee,

and how to report abuse. IBT programs are more common, perhaps because they are easier to administer. However, BST programs have delivered more promising results, especially in young children who require more active participation in order for information to be retained. (Brassard & Fiorvanti, 2015; Tutty, 2014) Thus, IBT programs may be more effective at facilitating a belief that one's own body is private and that the child and supporters of the child should be committed to protecting that privacy

Either program tends to be more effective when it is based on more objective touching guidelines rather instinctual-based approaches to inappropriate touches. Meaning it is better to give concrete definitions and scenarios that display appropriate and inappropriate touching rather than basing the appropriateness of touches solely on how it makes the child feel (Chen et al., 2012). Programs also lead to better outcomes when there are multiple components (Tuscano, Rubin, O'Brein, Coplan, & Thomas, 2015). Increasing knowledge on sexual abuse for children is not nearly as effective unless it is taught along with practical safety, communication skills and the ability to abscond. Instruction is most effective when followed by discussion and roleplay (Brassard & Fiorvanti, 2015).

In order to maintain a successful program it is recommended that suitable staff are selected, trained and supervised (Andrews & Bonta, 2010b). Implementers should be chosen based on their ability and potential to create strong bonds with students and should be given training that helps strengthen those skills. Staff members such as a school counselor, psychiatrist or administrative personnel should oversee the program in order to make sure that it is being implemented as intended. They should also help with ongoing skill development and training of personnel. Additionally, initiatives should expand awareness to parents and members of the

community in order to incorporate multiple layers of support for children (Brassard & Fiorvanti, 2015).

A program called "Safe Touches" is a secondary prevention program, in that it specifically targets high-risk children in grades kindergarten through 3rd grade (Pulido et al., 2015). The participants were considered high-risk due to their racially diverse student population and their low socioeconomic status. The intervention consists of a single interactive workshop that includes role-play scenarios to help develop trusting relationships with teachers and peers and provides a safety workbook that can be taken home and completed with parents. Discussion at home helps strengthen the parent-child bond and allows for program reinforcement.

The key concepts included in the program are private parts of the body, safe and unsafe touches, and the difference between safe and unsafe secrets. The program also enforces the ideas that inappropriate touches can come from adults that the children know or even trust, that children should not feel like they are at fault and that children should keep telling adults until someone listens and takes action. Confronting these misguided beliefs are especially important because children may naturally blame themselves for unfortunate circumstances or they may be told by a perpetrator that other adults will not believe them or that no one will help. Program coordinators aid children in making a list of effective ways to respond to unsafe touching and also the language skills required for reporting instances to trusted adults. Mental health professionals follow up with children who believe they have been touched inappropriately. Facts of the incidents are collected in a safe and private space and are reported as needed.

After the Safe Touches Program, children were significantly more knowledgeable on what inappropriate touches were compared to the control group. This was especially significant among the 2nd grade cohort. Additionally, the program proved to be effective when administered

to children with diverse backgrounds such as racial and ethnic minorities, and proved to be effective with children who came from less affluent families.

Another popular program is called "Stay Safe". The Stay Safe program was created to be delivered by teachers in an elementary classroom setting (MacIntyre & Carr, 1999). As recommended by the RNR model, school counselors are also utilized to oversee and support the program and do whatever is needed to communicate with children and parents in order to ensure active participation and understanding. Stay Safe couples multiple forms of abuse, physical, sexual and emotional, and bullying in order to create a broader prevention program for children from pre-kindergarten to 6th grade. The program is comprised of short 20 to 30 minute sessions, once a week for 9 weeks. Curriculum is taught through story-telling and offering scenarios that stimulate problem solving. Stories are then followed by discussion, roleplay, puppets, art and games.

Stay Safe focuses on building children's confidence and self-esteem, teaching assertiveness, communication, and cultural norms for personal space, while expanding children's feelings vocabulary. Safety skills are also emphasized such as communicating feelings of safety, identifying appropriate and inappropriate affection and secrets, identifying helpful adults and learning how to deal with strangers. The program also confronts the negative beliefs including self-blame and reminds the children that abuse is never their fault. Stay Safe also includes a minor family component. The program's website includes a parent friendly section that explains the program objectives and offers tips on how to discuss the topic with their children (MacIntyre & Carr, 1999). This component could considerably increase feelings of attachment between the parent and child and commitment to their safety, facilitating more protective action on the part of the parent and more open communication and disclosure on the part of the child.

A large-sample study evaluated the Stay Safe program, using children on the wait-list for the program as the control group (MacIntyre & Carr, 1999). The study found that safety knowledge and skills significantly improved. There was also an increase seen in the self-esteem on program participants under 7 years old. Significant improvements were also found in parent and teacher knowledge of abuse. The study also questioned willing children at a local sexual abuse clinic. The children were asked whether or not they had participated in the Stay Safe program. Those who reported participation had a greater likelihood of disclosing their abuse earlier and were more likely to disclose their abuse to school personnel, which could be due to building a stronger and more trusting bond with adult caregivers

Related research, not directly evaluating the Stay Safe program found a significant relationship between a child's level of self-esteem and the use of protective behaviors (Brassard & Fiorvanti, 2015). Children with higher self-esteem were more likely to use effective protective behaviors when presented with what-if scenarios. Children with lower self-esteem scores were less confrontational and less confident in their protective skills. Thus, it seems likely that building a child's self-esteem increases his or her commitment to self-protection. For this reason, it may be beneficial for abuse programs to focus on a child's individual strength and abilities during implementation. It may also help to give children positive feedback during knowledge recalling sessions or when practicing protective skills.

Overall analyses of child-focused programs conclude that the majority of interventions successfully teach children what childhood sexual abuse consists of and who children should talk to. Interventions that last for at least 4 sessions were found to be more effective compared to programs like, Safe Touches, who met less than four times (Tutty, 2014). This may be due to the difficulty in building a strong rapport with program facilitators when there are only a few

session, especially when the program discusses a sensitive topic. It is suggested that the number

of sessions is very important in determining the success of the abuse prevention program. In fact,

having shorter sessions more frequently lead to greater success than programs that met for a

greater amount of time, but in fewer sessions (Brassard & Fiorvanti, 2015). On average, sexual

abuse programs meet for 3 sessions.

The extent that CSA programs give children access to appropriate knowledge to help

deter victimization is variant on the length of the program, the age of participants and the level of

participation. Programs with more sessions that facilitate active participation are increasingly

likely to foster success, perhaps because it increases the level of involvement and perhaps

commitment to the program. In regards to age, studies differ on their findings in how well pre-

school children are able to apply techniques learned from CSA programs (Brassard & Florvanti,

2015). However, studies unanimously agree that older children are more likely to retain

information from the prevention programs for a longer period of time (Chen et al., 2012).

Children, when all age groups are averaged, retain information learned from CSA programs for

around 12 months (Tutty, 2014), which is a limitation to current programs. Increasing the

number of sessions and reinforcing past information each time may help prolong the recollection

of knowledge and skills. It may also be possible to provide less intense refresher courses

annually to returning students in order to bolster skills.

Like other prevention programs, results are also dependent on successful implementation.

Programs vary widely in who conducts them. Some programs are run by licensed counselors or

social workers, others are taught by teachers, parents or law enforcement officers. Although it

could be assumed that teachers, school staff or active parent volunteers could be more effective

facilitators due to their prior relationship with students, little research has been conducted on this

subject. Regardless of who conducts the program, training of any kind was found to significantly impact implementation success. Sexual abuse prevention programs can include training manuals or instructive multimedia. Only a few programs offer professional trainers who visit the school and conduct official instruction on a designated training site (Brassard & Fiorvanti, 2015). In the absence of training, research has shown teachers and daycare personnel often modify the program content to align with their personal morals, beliefs, or misconceptions on the topic (Johnson, 1994).

FAMILY COMPONENTS

Logically the family unit should play a major role in the prevention of sexual abuse because family members have the ability to create safer environments and limit the access of potential perpetrators (Wurtele, 2008). Educated parents would also be more effective at identifying signs of abuse and would know how to appropriately respond. Additionally, teaching parents also promotes more home discussion on the topic and an open communication style between parents and their children. Thus, home repetition for children may lead to a deeper understanding and may promote the recollection of knowledge and skills. An open communication style may also strengthen parental bonds and promote disclosure if victimization did occur. However, most CSA programs do not promote active parental involvement.

It is fairly common for parents to talk to their children about the dangers of strangers or accepting rides or gifts, in fact more than half of parents have that talk with their children (Zeuthen & Hagelskjaer, 2013). However, realistic scenarios of sexual abuse and appropriate responses are discussed far less often. Most parents believe myths about CSA and then pass these myths down to their children, such as describing sexual predators as strangers or "dirty old men" (Wertele, 2008). On the contrary, when it comes to sexual abuse, it is estimated that somewhere between 80% and 95% of sexual abuse is perpetrated by an individual known to the victim such as a coach, babysitter or family friend and 47% of perpetrators live or are related to the abused child. Knowing, trusting or even having a loving bond with the perpetrator may make it considerably more traumatic and confusing for the child, which is another reason there is a considerable need to for parents to help prepare and protect children from or support children through such scenarios.

When CSA programs lack parental involvement, as most do, they do not confront the need for adequate and accurate CSA home discussions. CSA programs without a parental component also miss out on strengthening parental commitment to their child's safety. The most commonly utilized form of parental involvement includes materials that are taken home and a follow-up to an in school intervention, which may end up being disposed of without review. A few programs, however, have offered parental education in how to identify signs of sexual abuse in children (Zeuthen & Hagelskjaer, 2013).

This lack of communication and knowledge between parents and children may be partially due to media coverage of childhood sexual abuse occurrences. The news tends to only cover the response of the criminal justice system rather than any information regarding the causes or solutions to CSA. Thus, common knowledge of CSA is not very useful for preventing it. In fact, limiting its exposure by only viewing harsh punishments in the news may provide a false sense of security that consequences are serious enough to deter perpetrators and are of little threat (Kenny & Wurtele, 2012). Thus, a more extensive parental component is needed to address the inadequacies of common CSA knowledge or myths, encourage discussion and to motivate parents to actively avoid placing their children in risky situations.

The Talking About Touching program contains a strong parental component. The program emphasizes to facilitators how important it is to involve families so that safety information can be repetitive and consistent between school and home and so children can be more confident that they have strong supportive bonds with both their parents and the school system. The intervention recommends conducting an initial meeting with parents to review the program and answer questions (Brassard & Fiorvanti, 2015). Doing so may help develop a trusting alliance between parents and teachers in order to holistically support children.

Parents and teachers watch a 30 minute video prior to their discussion. The video provides valuable information about sexual abuse and recommendations for providing a safe and positive home environment, realistic examples on how to discuss both sensitive topics and safety with children and guidelines for responding to disclosure of abuse, all of which strengthens the emotional connection between children and their caregivers. The video also helps inspire parents to take advantage of natural teaching opportunities to discuss important topics, how to utilize role play, and to examine who their children spend time alone with (Brassard & Fiorvanti, 2015).

Additional resources are also available to parents such as tips for choosing appropriate babysitters as well as pamphlets on child safety and signs of abuse, that allow them to effectively commit to their child's safety needs. Teachers are expected to send home handouts after each lesson for children and their parents to review together. Children are also encouraged at every session to share what they have learned with their parents (Brassard & Fiorvanti, 2015).

Research has come to several conclusions regarding parental involvement in abuse prevention programs. Parental components are often associated with greater success due to increased communication and comfort in the family unit and repetition (Kenny, Capri, Thakkar, Ryan & Runyon, 2008). Indirectly, the act of increased communication between parents and children on sensitive topics can positively affect their degree of attachment and may allow for an opportunity of a more open communicative style in the future (Brassard & Fiorvanti, 2015).

Additional studies concluded that abuse programs containing a parental component significantly improved parent's knowledge of sexual abuse (MacIntyre & Carr, 1999). Something as simple and cost effective as allowing parents to view an educational video on child sexual abuse urged more parents to become involved and discuss sexual abuse with their children. Knowledge of the subject and open communication between the parent and child allow

parents to help keep their children out of potentially abusive situations (Brassard & Fiorvanti, 2015). However, research considering barriers to parental involvement concluded that parental attendance in sexual abuse prevention programs were weak at best (Wurtele, 2008; Wurtele & Kenny, 2010).

CHILD-CARE PROFESSIONAL COMPONENTS

Past interventions have also targeted teachers, daycare professionals and healthcare practitioners. Rationally, it would be assumed that the amount of time teachers and daycare providers spend with children would facilitate a strong child-caregiver bond and the trusting nature of the relationship could be effectively utilized in order to lower incidents of CSA (Rheingold et al., 2012). Like parents, teachers who have built a rapport with can students can serve as a source for answering questions or disclosing sensitive experiences, such as CSA victimization. However, studies have shown that teachers have inadequate knowledge regarding the signs of sexual abuse and how to report it, even though they are considered mandated reporters. Additionally teachers also feel like they lack the ability to effectively talk to children about sexuality and how to avoid unwanted sexual advances (Barron & Tropping, 2013).

One such intervention is called, "The Seven Steps to Protecting Our Children", which is offered as an in-person workshop or as a web-based training. The main objectives for the prevention training were to learn about basic prevalence rates, risks factors and negative outcomes, how to minimize opportunities for CSA, discussing CSA with both children and adults, identifying the signs of CSA, how to effectively respond to children when they say they have been victimized, and motivating the community to become educated and actively involved in reducing abuse. One limitation to this type of approach however, is knowledge of the subject does not necessarily translate into behaviors that help prevent victimization. However, it may be beneficial to have a strong foundation of knowledge prior to learning how to facilitate behavioral change. In a recent study, the web-based CSA workshop was considered more cost effective and more comfortable for staff members. Overall for both the in-person and the web-based training, youth care workers deemed the training useful and indicated that they would be applying the

information to their professional lives as well as sharing it with others (Rheingold & Zajack, 2012).

Other programs include training for school personnel and daycare providers because they are the ones who implement the program in their institution. This may be especially helpful since actively discussing sensitive subjects can strengthen the attachment between children and trusted familiar school personnel. For example the Safe Child program requires teachers to deliver the content with help and supervision from the school counselor. Teachers and school counselors are given a training DVD before beginning the program, which teaches them about abuse, prevention research and the main program objectives.

The DVD teaches school staff members that rather than simply teaching children about abuse, the program aims to talk to kids about realistic safety and preventive behaviors. It instructs teachers to emphasize that children not go along with uncomfortable touching in fear of being impolite. The training DVD teaches school personnel to stray away from a "stranger danger" approach and helps teachers to work with children on skills to resist coercion. The "what-if" game is introduced as a crucial tool for staff. The "what-if" game introduces scenarios that require children and teachers to role play and practice positive skills such as being assertive, communicating clearly and asking for help. The DVD shows countless examples of role playing scenarios that teachers can script directly. For example, simple coercion should be used in role play as it would be in a real life, such as saying, "If you don't want to sit on my lap, does that mean you don't like me?" in order to prepare children for what an abuser might say. The training also recommends that the teachers practice initiating role playing scenarios with the counselor or each other prior to role playing with the children. Additionally, the training DVD also includes empirical evidence on the program, which conveys that participants are more likely to use safe

skills taught in the program when confronted with a potentially abusive or dangerous situation (Brassard & Fiorvanti, 2015).

Empirically, teachers who received training, whether it be in person, through a DVD or through web-based instruction were more comfortable and confident in their abilities to speak to children about abuse and build strong supportive relationships with them (Brassard & Fiorvanti, 2015). Personnel training in any component resulted in better implementation and thus a better outcome for students. Additionally, teacher instruction within the school system made the learning environment more comfortable for children, compared to an unknown professional conducting sessions on abuse.

MULTIPLE COMPONENT INTERVENTIONS

The most optimal prevention strategy will likely contain multiple components (Andrews & Bonta, 2010a) including child-based, family-based, and practitioner-based prevention in order to strengthen the attachment between children and their caregivers, and to increase the commitment of parents, teachers and the child to both proactive and responsive forms of child protection. Interventions should also address either primary and tertiary or secondary and tertiary prevention. For instance, CSA interventions addressing primary and tertiary prevention would teach all children in school how to address and prevent sexual abuse, while offering counseling and safe reporting to children who have already experienced abuse.

Secondary interventions that target a high-risk population, however have been determined to be more affective at reducing victimization, because it directs resources to the individuals who need it most (Andrews & Bonta, 2010b).A CSA intervention addressing secondary and tertiary abuse would teach an at-risk group of children, such as children between the ages of 7 and 12, children with violence in the home or developmentally disabled children, how to identify and deter sexual abuse, while supporting victims and reporting child abuse acts that have previously occurred.

The Who Do You Tell (WDYT) program is a program that considers all of these domains. It mainly functions as a child-based approach to CSA prevention aimed at children in grades kindergarten through 6th grade. Three groups are split up by age, the kindergarten to second grade group, the 3rd and 4th grade group, and the 5th and 6th grade group, with each group receiving age appropriate information and activities. Each group meets with their school counselor for two 60-minute sessions. However, before their classes start, their parents are invited to attend an informational meeting discussing the program, its content, and how parents

can reinforce its information. Additionally teachers are required to attend an in-service workshop prior to their student's sessions so they are able to handle any questions, disclosures or general reaction a student might have to the program (Tutty, 2014).

Children who attended the WDYT program showed a significant increase in their knowledge of appropriate and inappropriate touches compared to the control group. Research also suggests that children learned core CSA prevention concepts such as what population was most vulnerable to CSA, what private parts are, that touching is more often perpetrated by someone the child knows, and to not keep secrets about inappropriate touches. Children also learned that perpetrators could potentially use bribes or coercion. When interviewed, children found it helpful to use roleplaying and liked that pictures were introduced with key concepts. Overall, students reported very little anxiety or discomfort (Tutty, 2014).

LIMITATIONS

Some researchers have expressed concerns that sexual abuse awareness and prevention programs may unnecessarily frighten children that have little risk of being harmed by sexual abuse. It is feared that programs may drive children to be paranoid around adults, may create a fear of appropriate touches and may increase the rejection of normal affection. Other researchers are concerned that stressing the seriousness of CSA will give children nightmares. Studies discussing harmful outcomes from CSA preventions are often informal and consist mainly of parents or teacher observations after interventions have taken place. However, research consistently concludes that very few children experience negative side effects from CSA programs. Also the negative effects observed are mild and are short-lived (Tutty, 2014).

A meta-analysis reviewing the detrimental effects of CSA programs using 24 studies from 7 different countries found that school-based programs did not appear to cause harm to the participants. This was measured by anxiety and fear questionnaires completed by either the participants themselves of their parents up to six months after program completion. In fact, results concluded that program participants actually experienced less anxiety and fear than those who had not participated, although the difference was not statistically significant (Walsh et al., 2016). Little is known regarding parental fears after program completion or long term effects. Although it may be assumed that if there are no obvious short-term detrimental outcomes, that long-term negative effects are unlikely.

More formal studies should address this issue in order to officially determine what negative effects may occur, how often they occur, and how long they last. The fear of negative outcomes was included as one of the reasons that parents gave for not participating or not wanting their children to participate in CSA prevention programs (Wurtele, 2008). If these

detrimental outcome myths could be confronted prior to program implementation, it may ease

fears and increase program legitimacy and thus increase attendance and participation among

children and their parents.

Some researchers are also skeptical about CSA programs and preschool age children

(Barron & Topping, 2013). Children in younger age groups may not be developmentally mature

enough to understand the concepts of CSA or how to safely remove themselves from an

uncomfortable or dangerous situation. Since children under the age of seven are not as typically

targeted for CSA and are less cognitively capable of understanding concepts and applying skills.

Child-focused programs at this stage may make children feel responsible for self-protection

techniques that they are not mature enough to handle. This group of children may be more likely

to experience negative feelings towards the program and its message. However, it should also be

noted that when abuse does occur at younger ages and lasts for a significant duration, outcomes

are likely to be more severe. Thus, there may be a need to intervene in this age group (Walsh &

Brandon, 2012).

In response to these concerns Wurtele (2008) suggests that younger age groups might

receive the greatest benefits from a more intensive parental component prior to a substantial

classroom component. Educating parents on safety and signs of abuse would allow them to

protect their children from unsafe environments and detect and stop abuse early, if it did occur.

Also when parents are taught how to communicate openly with their children, children may be

more likely to vocalize feeling safe or unsafe in certain situations, which may help deter

opportunities for victimization. Finally, introducing a sensitive topic in a home environment may

ease the child's feelings of fear or anxiety when it is later introduced in a classroom

environment. At home children may feel more comfortable about asking questions and learning

from their parents, thus classroom interventions could serve as a review and a way to build skills when the child is cognitively capable to do so.

Another limitation suggested by existing research is that on average children only recall CSA information for one year after the initial intervention (Daigheault et al., 2012). Although older children are often able to recall CSA concepts and crucial skills for a greater period of time, younger children have difficulties recalling sometimes even prior to the one year mark. Therefore it may be appropriate to have an intervention including the child, parents, and school or daycare personnel for at least four sessions, which is indicated most effective according to research, followed by shorter less involved refresher sessions each year. Little research has been done on this type of approach, but it may be a way to help children recall information without the time and cost of administering the original program to the student body annually.

There is also an issue with how research has been conducted regarding CSA programs. Presently there is a deficit in the use of longitudinal research. Nearly all empirical studies follow-up shortly after the intervention and some also follow up somewhere between six months to a year to assess the children's knowledge of abuse and safety post-intervention. Currently it is known that the one-time interventions are limited to short term effects. However, programs that offer refresher courses to boost recall of knowledge and reinforce skills should assess participants for longer periods to determine effectiveness. In the future longitudinal research would also be helpful to determine whether strengthened bonds from the program were short-term or whether they had long-lasting effects. It would also convey any general positive or negative long-lasting effects from the program and allow for a better picture regarding safety skills utilized by students and how programs affect the time of disclosure (Brassard & Fiorvanti, 2015).

As with most prevention programs, lack of funding is also a concern (Barron & Topping, 2013). Both the government and schools have limited resources so programs must compete for funding. Thus, CSA prevention programs must be deemed cost-effective to be practically considered.

A recent study attempted to determine the cost-effectiveness of a CSA program that included a school-based component that utilized active discussion and role play (Barron & Topping, 2008). The program is composed of four 50 minute long sessions, which included follow-up measures for students who disclosed abuse and training for presenters by the program author. The training was one hour long and included curriculum objectives, content, delivery style, limitations of confidentiality and how to respond to disclosure. The cost for this program was $1,101. 78 per school or $61 per disclosure. The bulk of the cost went to paying presenters. Although there has been little research done to determine the cost-effectiveness of CSA programs, studies that have been conducted suggest that such programs are a fairly inexpensive way of increasing self-protective knowledge and behaviors as well as the amount of CSA disclosures.

SUGGESTIONS FOR FUTURE INTERVENTIONS

If more prevention strategies could include a stronger parent component in which parents participated and were actively engaged, guardians could become a great asset to preventing childhood sexual abuse. Research suggests that in many programs parental participation is weak. However, studies have also concluded that parents are willing to talk to their children about sexual abuse, but do not feel competent on the subject. They also report being unsure of the correct vocabulary and lacking resources to share with their children. Additionally parents admitted that they were uneducated on warning signs of sexual abuse. Parents' current knowledge of sexual abuse and its prevention could still be misinformed due to widespread myths such as believing it does not happen to affluent families, that a child would tell if something was going on, or that certain characteristics must be present for a person to be a perpetrator (Walsh & Brandon, 2012). Therefore, it appears that parents are willing to discuss abuse with their child and are in need of guidance, however, many do not take advantage of the programs that address that very issue. Research should be conducted to conclude what prominent barriers are keeping willing parents from program participation and what can be done to stimulate greater parental involvement.

One reason parental involvement with CSA programs may be low is due to time restraints that many working parents face. In order to combat this barrier, it may be important to offer a program alternative that parents can complete on their own time. There are presently a few existing Internet-based interventions focusing on parent-child dyads, though they do not specifically cover the topic of childhood sexual abuse (Kenny & Wertele, 2012).

Internet-based programs that help support the parent domain could be a vital tool to either introduce the idea of CSA in the home setting or to supplement what a child has already learned

at school. Research has also shown that web-based prevention programs make the sensitive subjects like CSA more comfortable for participants. Additionally, a child's level of comfort with their parents compared to school personnel may encourage children to ask more questions and thus, learn and retain more vital information. Ideally such a program would be broken up into two components, one intervention directed at children, similar as to what happens in a school setting. The other portion of the prevention strategy would also include information for parents regarding signs of abuse, how to report suspected child abuse and how to help children recall crucial prevention information that they may have forgotten over time (Rheingold & Zajack, 2012).

There is also a need to focus more research on the parents of children in abuse prevention programs due to their unique ability to foster a safe environment for their children and because strong parental attachment is likely to bring out earlier abuse disclosure (Wurtele, 2008). Some programs offer parental training on how to strengthen parental bonds by talking to their children about sensitive topics, how to identify signs of abuse, and facts about abuse, that may challenge previously held beliefs. Other programs offer other materials such as tips on finding safe babysitters and questions to ask your child about their alone time with others. Parental involvement may be as simple as sending home session summaries of the program or sending home an activity book for the child and guardian(s) to complete together. Though all of these components could be helpful, it is important to conduct research on various parental components to decide what sources parents are more likely to utilize and what resources helped strengthen trust and communication between them and their children. It is assumed that many programs have limited funding, thus it is important to allocate funding to intervention components that have been shown to be empirically beneficial.

Additionally, research has suggested that there are specific barriers for parents, especially mothers, in reporting the sexual abuse of their children. Parents may be in denial that sexual abuse exists and may ignore the problem and not provide support to the child after disclosure, especially if the social bond between the parent and child are weak. Women may be romantically involved with a man who is abusing her children and perhaps her as well. Therefore she may fear the complications associated with reporting him. Parents may also fear being ostracized from the family if they report abuse. They fear reporting may bring shame to their family, or that if the abuser is a well-liked relative, he may manipulate the family into believing his story over the child's (Taylor & Norma, 2013). Few if any programs have considered looking at family barriers that may weaken the social bonds of the parent-child relationship in their prevention approach. A successful prevention program must confront common barriers families face and suggest ways for handling them while keeping the child's best interest in mind.

CSA programs should also embrace diversity. Currently only 17% of CSA programs take diversity into account when discussing victimization and only 33% differentially address the special needs population, such as children who are mentally or physically disabled, even though they are among the most vulnerable. Little has been done to specifically educate this population or their caregivers on how to effectively deter victimization in this group (Kenny & Wertele, 2012). For schools who have a deaf child or children, a person who knows sign language should also attend in order for the children to receive the message. For children who are developmentally disabled, information should be administered to them in a way that is appropriate for their cognitive level. Parents of children with disabilities should be especially targeted since their children are among the highest risk for victimization and among the least likely to understand what abuse is.

Based on research suggestions, the ideal program would include many necessary components. Teachers would be trained on abuse and safety strategies prior to implementation in order to increase their legitimacy when speaking to the students. Teachers, counselors or administrative personnel would find ways to motivate parents and community involvement with the program. Parents should be included prior to intervention so they can receive information on abuse, the program itself, and how to talk with their children about abuse, reinforce knowledge and skills learned in the program and develop a more supportive relationship.

In accordance with the specific responsivity principle, intervention should be audience specific, meaning it should be age appropriate, should consider cultural differences, and should accommodate physical and mental disabilities. It may also be beneficial to develop a more intensive intervention for children ages 7-12, children who have violence or substance abuse issues in the home or who are developmentally disabled, since they are considered to be the most at-risk for sexual abuse. Session lengths can be brief, but should be taught in no fewer than 4 sessions in order to strengthen children's involvement and commitment to the safety fundamentals of the program. Sessions should also be evaluated by a school administrator or program director in order to ensure that the program is being implemented as intended.

According to the principle of general responsivity, teaching methods should vary and should include active components such as discussion, role playing and positive feedback to build knowledge and encourage behavioral change. Program content should focus greatly on skills relating to assertiveness, open communication with trusted adults and safety. Children should be encouraged to discuss what they have learned with their family and some form of take-home material should be offered to inform parents or facilitate parent-child discussion. Anytime during or after the program staff members should create a safe and confidential space for children to

disclose abuse. As a mandated reporter, staff should file a report and follow up with a counseling assessment and plan to meet the individual needs of that specific child.

The program should be offered annually to new students and a modified version should also be offered to returning students in order to refresh their memory and review skills. Additionally, a school counselor, psychologist or administration should be keeping track of the effectiveness of the program by administering questionnaires to students, teachers and students. This individual should also remain up to date on abuse prevention research so implementation can be altered as needed in order to make the program more efficient.

PROPOSED MEASUREMENT

The most common way to determine whether behavioral change has occurred is to use simulations or observations. In the past simulations have been utilized to observe what children had learned about the dangerousness of strangers. Of course, allowing unwanted touching of any child for any reason is unethical. So instead many CSA researches base their evaluations off changes in attitude and knowledge of the subject matter. Most studies to test effectiveness, have followed up with questionnaires for children, teachers, or parents. Common questionnaires assessed children's basic knowledge of abuse, awareness of scary secrets, safety knowledge and skills, choice of safety strategies and what-if situations questionnaires (Brassard & Fiorvanti, 2015; Chen et al., 2012). Only a few studies have also use a longitudinal approach. Among these, it has been found in regards to the tertiary prevention component, that victims of sexual abuse who had previously participated in a school-based CSA program had a higher likelihood of reporting abuse to their teachers and their claims were more likely to be verified (Brassard & Fiorvanti, 2015).

In order to evaluate the effectiveness of the CSA program, two similar schools would need to be selected at random. The first school would be given a standard intervention program that takes place in a school setting consisting of two to three sessions teaching the very basics of what sexual abuse is, what is appropriate and inappropriate touching, how to safely flee predatory situations and who to tell. This group would serve as the control group. The second school would facilitate an intervention based on the research-related recommendations, meaning it would cover the basics but also include teacher training, and a parental component to strengthen children's bond to caregivers, would last at least 4 sessions and so on. . Creating two

separate groups will help determine whether the holistic social bond component contributes to a more effective CSA school-based program for children.

Prior research evaluates the effectiveness of CSA programs based on pre and post-intervention evaluations looking almost exclusively at the knowledge children have gained from the program. Because knowledge and action are not perfectly linked, an increase in knowledge is not sufficient to confirm behavioral change. However, knowledge is likely a fundamental precondition to behavioral change and must be evaluated.

Lewis, Scott and Hendricks (2014) have broken down knowledge into three separate types, declarative, procedural and reflective. Declarative knowledge is the basic foundation of learning a new subject, consisting of memorizing facts and definitions. In order to test knowledge at this level, children could fill out a questionnaire explaining basic information about what abuse such as what constitutes sexual abuse, who can be perpetrators, what mandated reporters are and so on.

Procedural knowledge is the development and application of skills (Lewis et al., 2014). The main skills in need of evaluation for the school-based CSA program would be safety skills, communication skills, and assertiveness, whereas the main skill from the after-care component would be coping skills. In order to test procedural knowledge, vignettes would be helpful in setting up scenarios to determine if children can apply what they have learned to real life scenarios including those that involve coercion or realistic barriers like not wanting to get a family member in trouble.

Reflective knowledge is the deepest form of knowledge, which includes continuous refinement of declarative and procedural knowledge (Lewis et al., 2014). This type of knowledge would include the ability to reflect, adapt and problem solve in order to navigate through the

barriers that may present themselves in dealing with threats or the aftermath of sexual abuse. In order to test this form of knowledge, vignettes could also be used, for example, what can you do if a parent does not believe you when you disclose?

In order to go beyond knowledge evaluation, measurements from a similar school-based intervention for children who have experienced or witnessed violence in the home and the children's parents (Santiago, Lennon, Fuller, Brewer & Kataoka, 2014) have been borrowed. Witnessing violence or being physically abused can have similar outcomes to those of CSA victims such as post-traumatic stress disorder, anxiety, depression, behavioral problems and school problems. Thus, since this program takes place in a school setting, contains a parental component, looks as trauma and evaluates similar behavioral outcomes, their measures should be sufficient for evaluating the proposed CSA program.

Child victims who participate in the after-care program, should be assessed initially after disclosure prior to receiving services, assessed again after 6 months, and again after one year, if available. The Child PTSD Symptom Scale (CPSS) is a self-report measure that can be utilized to assess the frequency of all the PTSD symptoms as defined in the Diagnostic and Statistical Manual for Mental Disorders-Fifth (DSM-V) (Santiago et al., 2014). 17 items lead to a final score, a total score of 17 is categorized at the highest symptom severity, 14 or higher was moderate to severe, anything below a 14 meant symptomology is considered to be low symptom severity.

In order to address depressive symptoms in children, participants can fill out a Child Depression Inventory (CDI) (Santiago et al., 2014) which assesses a child's levels of depression as well as its effect on social behaviors. A child's level of depression and anxiety can also be assessed through a parent's observation through the Pediatric Symptom Checklist (PSC). The

PSC is made up of 35 brief statements of problem behaviors that include both internalizing (depression, anxiety, maladjustment etc.) and externalizing behavior (conduct, attention, aggression etc.) symptoms. It is also important to assess how children are coping with their victimization and how parents are helping or hindering that process. The Responses to Stress Questionnaire (RSQ) is a short and reliable assessment that includes various types of healthy and unhealthy coping styles and strategies that can be filled out by both the child and adult participants.

In addition to assessing knowledge, skill application and behavioral change in children, it would also be helpful to understand how satisfied children, parents and staff are with the program and to what degree parents participated. In order to examine this, a questionnaire using 5-point scale ranging from very dissatisfied to very satisfied will be used. Questions for children should examine how comfortable they felt discussing the subject and role playing with staff. It can include other subjective questions such as how beneficial and enjoyable the activities were. Questions for parents and staff should examine their observation of children's response to the program, progress made in the relationships with the children, and how helpful they found either the teachers' training or the parental training. For the parents, an open-ended question will be asked in regards to what resources they found most helpful (i.e. tips to find a safe babysitter, tips on how to discuss sensitive subjects, signs and symptoms of abuse etc.) and a space will also be left for written feedback.

There will also be a questionnaire given to the students, parents, and school personnel to assess social bonds (Chapple, McQuillan, & Berdahl, 2005). The attachment and belief components of the questionnaire will be given prior to the program, immediately after the program, 6 months, and one year after the program. This will help determine whether the

program was able to strengthen these bonds and if the change remained post-intervention. All questionnaires will incorporate a 5-point scale ranging from strongly agree to strongly disagree.

The attachment questionnaire will assess the emotional strength of the caregiving relationship as well as the degree of direct and indirect control (Chapple et al., 2005). The children's questionnaire will evaluate both the parent-child relationship and the teacher-student relationship. An example would be, "I discuss academic or social concerns with my teachers" or "I share thought and feelings with my parents". Direct control will be assessed by asking questions such as, "When I am not at school, I am usually with my parents in a setting where they can either see or hear me". In order to measure indirect control, children will be asked the degree of influence teachers or parents have on their decision-making process when they are absent. The parent and teacher questionnaire would also include questions about communication with the child(ren) and monitoring habits.

In order to measure commitment to the program children, parents and teachers will be assessed on how much they conformed to the expectations of the program. For example, parents, teachers and children could be asked much they agree or disagree with statements such as, "I have spent time outside of what is required by the program discussing sexual abuse". Additionally, parents and teachers could be asked to what degree they have incorporated tips from the program into interactions with children or other adults who spend time alone with children.

Involvement, according to theory is largely the participation in an activity. Therefore, to measure involvement, questions will center on forms of active and passive participation to determine the extent of the participant's engagement. It would also assess if the parents did or would be willing to communicate with the school staff including teachers and counselors in

regards to the CSA intervention (Santiago et al., 2014). Additionally, parental participation rates will also be compared in order to determine whether actively encouraging participation increased attendance.

The final component, belief, will examine the degree to which internalized ideas regarding CSA have changed over the course of the program. Practical application questions and scenarios can be given to children as a way to test whether or not they will actively incorporate program components. For example, a child would be asked to what extent they agree or disagree with the statement, "If an adult makes me feel uncomfortable by touching my body or invading my personal space, I should tell a trusted adult". Belief measure can also examine protective and reporting behaviors in adults, as well as how well children, parents and teachers can identify common myths about CSA.

CONCLUSION

Childhood sexual abuse negatively affects children of all ages all over the world. Preventing initial and further CSA is not only important for the psychological well-being of the victim, it is also important for families, society and the criminal justice system. Individuals who are sexually abused as children are far more likely to grow up and commit crimes of a sexual or physical nature. For those who have already experienced sexual abuse, early disclosure and counseling are crucial in order to deter criminal offending and other negative outcomes that lead to a diminished sense of well-being. Although CSA is an uncomfortable topic for many, the cost to victimized children and society as a whole is too high to ignore.

Some CSA prevention strategies are already in place. Most programs target children through the school system at large, while others target groups that research deems to be more at risk. Some interventions also attempt to involve parents and school or daycare personnel, giving them the tools to encourage discussion, detect signs of abuse, and report suspected abuse. Even though some schools provide CSA interventions, many of them still do not and parent and teacher prevention programs are even rarer.

Hirschi's (1969) social bond theory is a common explanation for offending. However, little has been done to relate how the strength of bonds affects victimization, although the theory would most certainly apply. Research should incorporate more victimization into the social bond literature to determine how a child's attachment to parents and schools affect the likelihood of victimization. This knowledge could help further the understanding of how the role of parents and school personnel can further support and protect children from acts of victimization.

Beyond problems of, not involving parents and teachers lacking a holistic approach that strengthens bonds between children and adult advocates, there is also unanswered questions in

research and problems with implementation. Parents claim they are willing to help but are largely left out of school-based interventions and show weak participation in programs that do try to include them. The internet could also be used to more effectively educate children, parents and child care professionals on their own time, in a private and cost effective manner. Another problem implementation is programs do not currently take diversity or special needs into account, even though they are at an increased risk for abuse.

Research points to several ways in which childhood sexual assault programs could more effectively prevent future victimization and help alleviate negative consequences for children who have already sexually abused. If prevention programs could apply Hirschi's (1969) social bond theory and research to address their current downfalls CSA programs would undoubtedly increase their effectiveness. An efficient approach would in turn spare children, families and communities from extensive harm.

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