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A Parent-focused Child Sexual Abuse Prevention Program: Development, Acceptability, and Feasibility

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Abstract

Objectives: Child sexual abuse (CSA) affects nearly 60,000 children in the U.S. annually. Although prevention efforts targeting adults in the community and school-aged children have been somewhat successful, there is a clear gap in the current prevention efforts: parents. Generalized parent-education (PE) programs have effectively reduced the rates of physical abuse and neglect; however, currently no PE program targets risk factors for CSA specifically. We sought to develop a brief module to be added onto existing PE programs thereby leveraging the skills and implementation infrastructure to ensure sustainability.

Methods: In three phases, we developed the curriculum, refined content and presentation while simultaneously developing and psychometrically evaluating a measurement tool, and conducted an acceptability and feasibility pilot. These phases are described in detail such that intervention scientists wishing to develop a module to be added onto existing programs can follow our procedures.

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Author Contributions: KG designed and executed the study, oversaw data analyses, and wrote the paper. KMZ collaborated in the execution of the study and writing of manuscript. JMR assisted with data analyses and wrote part of the results sections. JS collaborated in the design and writing of the manuscript. JGN oversaw the design, execution, and data analysis as well as writing of the manuscript.

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Ethics approval and consent to participate: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all individual participants included in the study. The Pennsylvania State University Institutional Review Board provided approval for this study.

Conflict of interest: The authors declare that they have no conflict of interests.

Results: The results of each phase are described so that the reader can see how information gleaned in one part of a phase informed subsequent phases of research. This was an iterative process of development, refinement, and piloting.

Conclusions: The resultant module is designed to be added onto extant evidence-based PE programs. The module, and the additive approach of the intervention, will be evaluated in a future randomized controlled trial.

Keywords

child sexual abuse; intervention development; acceptability; feasibility

Child sexual abuse (CSA), a subtype of child maltreatment attributed to 8% of substantiated reports in 2016 (DHHS, 2018), includes completed or attempted sexual acts, sexual contact, or exploitation of a child under 18 by a caregiver or adult (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Leeb, Paulozzi, Melanson, Simon, & Arias, 2008). Substantiated cases represent only a small proportion of CSA—retrospective reports suggest 1 in 10 children experience CSA before age 18 (Townsend & Rheingold, 2013). The lifetime economic burden of CSA is estimated to exceed \$9.3 billion (Letourneau, Brown, Fang, Hassan, & Mercy, 2018) and consequences include depressive symptoms, posttraumatic stress disorder, eating disorders as well as poor physical health outcomes including obesity and early pubertal timing increasing risk reproductive problems (Hornor, 2010; Noll et al., 2017; Noll, Zeller, Trickett, & Putnam, 2007; Pérez-Fuentes et al., 2013). Those with a history of CSA have an increased risk for revictimization and to engage in sexual behaviors, delinquent behaviors, and substance use—all of which set the stage for costly adult outcomes (Barnes, Noll, Putnam, & Trickett, 2009; Hornor, 2010; Noll, 2005; Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003; Noll, Trickett, & Putnam, 2003). CSA is a considerable public health problem in need of a unique prevention strategy.

CSA prevention strategies began in earnest in the 1980s. Community- and school-based interventions integrate primary (i.e., awareness strategies) and secondary (i.e., identification of signs of CSA and how to respond) prevention techniques. *Stewards of Children*, a widely disseminated community-based prevention program, targets adults in the community and trains participants how to prevent, recognize, and respond to CSA. In a randomized controlled trial (RCT) among childcare professionals, those that received the program had a significantly higher knowledge of CSA, lower endorsement of myths, and used a higher number of protective behaviors such as talking to another adult or child about CSA, changed organizational policies, or calling a CSA hotline (Rheingold et al., 2015). Evidence suggests *Stewards of Children* increases rates of reports of CSA to proper authorities, but it is unknown whether increased reporting leads to a decrease in the incidence of CSA (Letourneau, Nietert, & Rheingold, 2016). School-based programs are victim-focused and teach children how to identify and report CSA. *Safe Touches* is a school-based prevention program for second and third grade aged children. In a 50-minute interactive, puppet-based workshop delivered in the classroom, children learn to discern safe and not-safe touches, the difference between secrets versus surprises, and what to do if they experience a not-safe touch. In a RCT of 437 children, those who received *Safe Touches* had a significant improvement in knowledge of inappropriate touch compared to those who did not receive

the program (Pulido et al., 2015). The positive effects of community-based programs and child-focused school-based programs is encouraging and in support of a one-time program delivery, though longer follow-up periods are needed to ascertain the maintenance of these gains. General awareness raising among adults accomplished through community-based programs and victim-focused school-based programs is important, but omit a theoretically justified prevention target: parents. Parents are important agents of prevention for a number of public health problems affecting children, including substance use (Dishion, Kavanagh, Schneiger, Nelson, & Kaufman, 2002; Kumpfer, Alvarado, & Whiteside, 2003), delinquency (Mason, Kosterman, Hawkins, Haggerty, & Spoth, 2003) and obesity (Andrews, Silk, & Eneli, 2010; Lindsay, Sussner, Kim, & Gortmaker, 2006). Parents play an important role in the prevention of child maltreatment generally. Why then should we not consider parents in the prevention of CSA?

The call for the inclusion of parents in CSA prevention is decades old (e.g., Daro, 1994); however, a limited number of studies report the results of parent-focused prevention programs. Berrick (1988) examined the efficacy of educational meetings offered to preschool parents with the goal of increasing knowledge and reducing misconceptions of CSA. No statistically significant improvements in knowledge or behaviors were observed among those who attended these voluntary meetings (only 34% of the study sample) compared to those who did not. In fact, those who attended the PE meetings were less likely to discuss CSA with their child. Burgess and Wurtele (1998) examined the effect of a 30-minute video of parent-actors modeling discussions of sexuality and touching safety with a child as well as handling a disclosure of sexual abuse. Compared to parents who received a generic safety video, those who received the CSA prevention-focused video were more likely to express intention to discuss CSA with their child and at follow-up, 2 to 8 weeks later, were more likely to report having had that conversation. Despite the provision of free transportation and childcare during the CSA workshops, the authors reported low attendance. The low participation rates and poor parental engagement in the Berrick (1988) and Burgess and Wurtele (1998) intervention studies indicate parents are unlikely to enroll in a voluntary CSA prevention program, but poor parental engagement is not unique to CSA prevention programs (Guastaferrero, Self-Brown, Shanley, Whitaker, & Lutzker, 2018). A short, voluntary program can be effective. Wurtele, Moreno, and Kenny (2008) examined the effect of a three-hour workshop designed to promote parent-child communication and protective environments among parents of young children. A significant improvement in knowledge about CSA and increase in communication with children about CSA was reported among those who received the CSA workshop. These prevention approaches inform the needed unique prevention strategy in two important ways: parents cannot be expected to voluntarily attend yet another prevention program and short, one-time programs can be effective in improving parent knowledge and behavior.

Rudolph et al. (2018) suggested the utility of embedding a CSA module into existing evidence-based parent education (PE) programs. PE programs are designed to modify knowledge, attitudes and behaviors about child development, increase positive parent-child interactions, improve parental mental health symptoms and reduce problem behaviors exhibited by the child (Lundahl, Nimer, & Parsons, 2006; Timmer & Urquiza, 2014). PE programs are often disseminated on a large scale and have robust implementation

infrastructures (e.g., rigorous training, fidelity monitoring, and financial support). PE programs, such as SafeCare® and Incredible Years, have demonstrated a significant reduction in risk for neglect and physical abuse, but generalized PE programs have not affected rates of CSA (Letourneau, Eaton, Bass, Berlin, & Moore, 2014; Self-Brown, Whitaker, Berliner, & Kolko, 2012). This is not surprising as CSA is distinct from other forms of maltreatment in meaningful ways for prevention efforts. CSA, like other forms of maltreatment, is likely to occur under a confluence of individual and contextual factors such as parental substance use, parental mental illness, or poor parent-child relationships (Rudolph et al., 2018). However, distinct environmental risk factors contribute to perpetration of CSA, making it possible to identify unique targets for CSA prevention. Unlike other forms of maltreatment, the most common perpetrators of CSA are adults and older children who are known by the child and family, rather than biological parents (Finkelhor & Shattuck, 2012); 64% of the perpetrators of CSA are non-familial, whereas 28% of physical abuse and 8% of neglect are non-familial (Sedlak et al., 2010). The elevated risk victimization by age groups is markedly distinct for CSA. The youngest children are the most vulnerable to maltreatment—29% of all maltreatment reports made to child protective services in 2016 were among children under 3 (DHHS, 2018). However, children between 7 and 13 years old are at greatest risk for CSA and the median age of victimization is 9-years-old (Finkelhor, 1994; Putnam, 2003; Sedlak et al., 2010). CSA is often a result of opportunity when an adult has excessive one-on-one time with children where grooming (i.e., tactics used by a perpetrator to gain a child's trust, creating the potential for abuse; McAlinden, 2006) is possible and occurs in environments where children are unsupervised. The vast majority of CSA occurs during times of minimal supervision (e.g., 8:00 a.m., 12:00 p.m., and 3:00–4:00 p.m.) (Snyder, 2000). Although there is a high rate of co-occurrence between CSA and other forms of maltreatment (Dong, Anda, Dube, Giles, & Felitti, 2003), the unique features of CSA are not a part of current child maltreatment prevention strategies. CSA prevention is less about changing parental behaviors as is typical of broader child maltreatment PE programs. Rather, CSA prevention programs are about teaching parents to create a protective environment. As Rudolph et al. (2018) suggest, a parent can directly prevent CSA by increased involvement in their child's life and enacting supervision and monitoring skills, but can also indirectly prevent CSA by encouraging their child's self-efficacy, self-esteem, and confidence. The most effective CSA prevention effort is one that reduces the environmental risk (i.e., potential abuser's access to children), increases awareness of CSA, and teaches how to recognize and report signs of sexual abuse (Kenny & Wurtele, 2012; Wurtele & Kenny, 2012). Parents are in a unique and vital position to advance CSA prevention and create a protective environment. Generalized PE programs provide a good foundation of child development and basic parenting skills such as communication and safety, and several have been effective at preventing physical abuse and neglect. If general PE programs included sexual abuse content, then it is possible generalized prevention programs could also impact rates of sexual abuse.

We developed a brief module to be added onto existing PE programs that have demonstrated effective reduction in rates of physical abuse and neglect. By leveraging the implementation infrastructure of, and augmenting the fundamental parenting skills taught by widely disseminated evidence-based PE programs, we believe the addition of CSA-specific content

to an established PE program is an efficient, economical, sustainable, and innovative CSA prevention strategy. In this paper, we describe the three-phase process of: (1) developing a curriculum, (2) rapid-prototyping the curriculum with end-users (i.e., parents and providers), and (3) conducting an acceptability and feasibility pilot. The purpose, method, and results are presented separately for the activities of each phase to detail the process for other researchers interested in designing a module to be added to existing curricula. A future publication will present findings of a RCT examining the effectiveness of this module. This research was approved by the Institutional Review Board.

Phase 1: Content Development

Our intention was to create a brief easily implemented module that would be added to existing PE programs to leverage their implementation infrastructure and reach with families. As such, the objectives of Phase 1 were to (a) solicit input from experts (i.e., model developers, CSA researchers, and intervention scientists), parents, and providers; (b) compile content of existing CSA programs; and (c) distill all input to select essential components of a CSA prevention module. Phase 1 concluded with the creation of an initial draft of the parent and provider materials.

Expert Panel Meeting

Method.—A panel of 10 national experts including PE model developers, CSA program purveyors, senior CSA researchers, and intervention scientists, as well as dissemination and implementation specialists was convened. The experts identified essential elements from existing CSA prevention programs (not solely parent-focused) and brainstormed additional elements to include. Model developers were asked to weigh in about the implementation of a module focused on the risk and protective factors specific to sexual abuse. Specifically, model developers were asked to comment on the feasibility of integrating (i.e., *systematic braiding*; Guastaferrero et al., 2017) this specific content into the existing session guides or adding the content on as a unique session during typical implementation. The panel concluded by outlining the goals of the module to be developed, the content areas (i.e., themes) to be included, and the mechanisms (i.e., tools) for teaching parents concepts and skills. The expert panel was asked to share previously developed parent-focused materials with the research team.

Results.—The panel of experts identified the goal of the module as fostering healthy sexual development and preventing victimization. Six essential elements were identified: basic knowledge (i.e., definitions and myths); communication (i.e., talking about sex with children, discussing rules with other adults); safety education (i.e., supervising and monitoring, vetting adults with whom they leave their children, environmental and child cues); sexual development (i.e., normative and non-normative behaviors); internet safety (i.e., exposure to media, child's activity, access by other adults); and facilitating disclosure (i.e., what to do if CSA is suspected, how to respond to a disclosure). Proposed mechanisms for relaying information and skills to parents included handouts, vignettes, and facilitated discussions. The expert panel suggested the module be added on to the end of typical implementation of the PE program for several reasons. First, the additive approach compared

to the integrated approach ensures the fidelity of the PE program. Second, the additive approach makes the implementation of the CSA content feasible and affordable. Third, delivered in this way, the added CSA module is able to build upon the core parenting skills taught in the PE program. The panel, particularly the providers, reiterated the need for the CSA content to be delivered within one session.

Insight Interviews

Method.—Following the expert panel meeting, semi-structured interviews were conducted with providers of PE programs to learn about how they introduce and/or respond to challenging topics (e.g., sex, discipline, new partners) with parents on their caseload and how they teach parents to have these conversations. In turn, parents were also asked how they discuss these difficult topics with their children, how they prepare for difficult or challenging conversations they have had or are anxious to have with their children. Topics generated by the parents included discipline following an undesired behavior, changes to family structure, and sexual development or behaviors. The interviews sought to understand the differences in location, duration, and feelings elicited by difficult conversations. Parents were also asked to describe how their parents had discussed sexual development in their childhood and how this influenced (or will influence) the way they discuss sexual development with their children.

Eight providers (all female) from local non-profit service-providing community-based agencies were interviewed. Each provider served 6–10 families and half had been trained in an evidence-based parent-education program. To recruit parents, we asked these providers to provide flyers to families on their caseload and recruited five parents in this way. An additional eight parents were recruited through broader community advertising. Parents were eligible to participate if they had a child under 18. The 13 parents recruited reported a total of 24 children ranging in age from 5 months to 18 years old. Provider and parent interviews ranged in duration, 60 to 90 minutes, which was in response to the flow and level of detail of the conversation. All interviews occurred in a private room at the university. Two members of the research team were present at each interview: one conducted the interview and one took detailed notes as the interviews were not audio recorded. Notes from the interviews were de-identified and all participants were compensated at a rate of \$25 per hour; each participant was compensated for two hours.

Results.—Providers indicated common challenges when working with families included presenting topics about which the parent was resistant to change, deciphering truth from fabrication, and addressing when a parent's direct actions contribute to poor child outcomes. All providers emphatically indicated they talk about sex with the parents they serve. When probed, the providers specified these conversations were limited to topics such as marital issues, how to discuss the difference between the parents' sex life and their child's sex life, and talking about safe relationships among parents with a history of sexual abuse. Hence, these providers were not educating parents on their caseload about how to talk to their children about sex, sexual development, and sexual behaviors. Providers described their role in helping parents learn how to prevent sexual abuse as follows: talking about Megan's Law (i.e., federal law requiring registration of sex offenders), noticing children's behavioral or

emotional cues that “something is going on”, teaching a child to respect their body, and how to teach children about who can touch them and under what circumstances. Providers identified the most common questions parents asked were about how to discuss masturbation, whether a given behavior was normal, if the parent had responded to a child’s question correctly, or the age at which it is appropriate to discuss sexual behaviors. When responding to a difficult topic raised by a parent, providers emphasized their priority was maintaining the safety of the child (e.g., asking how a situation may affect their ability to parent) and how it was important to respond in a calm manner validating parents’ concerns.

Parents identified topics that were difficult to discuss with children including sex, sexual abuse/assault, alcohol, pornography, and PTSD or other mental health concerns. The appropriate age and developmental stage for discussing these issues with their child was the most common concern for parents. Several parents expressed concern about presenting too much detail about sex too early, as this would potentially lead to their child engaging in these behaviors earlier than desired. Parents were asked to describe how *their* parents had spoken to them about sex. When sex was discussed, the parents noted it was highly uncomfortable and a one-time conversation. When sex was not discussed, the most common source of information about sex came from friends or older family members. Parents were asked how their experience has shaped or will shape how they discuss sex with their own children. Parents indicated they believed sex was important to discuss, that it should be an ongoing conversation, and that children feel comfortable asking questions. Parents described questions their children have had regarding sex and where these conversations take place. Parents reported children having questions about sexual development, where babies come from, safe sex practices, and masturbation. These conversations were generally brief and often took place *in situ* (i.e., bath time, following a well-child checkup, following the birth of a sibling). With regard to creating a protective environment, parents were asked about how they become comfortable leaving their child with a new caregiver or a friend’s family for an extended period of time. Parents suggested first hanging out as a family so that the parents could get to see how adults interact with their child, talking with the parents of the new friend about rules, and checking in with their own child about what they did. Finally, parents spoke about how they monitor online activities. Suggestions included keeping the computer in a communal space, acquiring the passwords for all social media accounts, and only having one streaming account in the home.

Summary

The purpose of Phase 1 was to solicit, gather, and distill information from experts, parents, and providers. The research team categorized existing program content provided by the expert panel and comments from insight interviews into six essential prevention elements: basic knowledge (e.g., definitions); communication; safety education; sexual development; internet; and facilitating disclosure. Content that may have fit several of these essential elements was included in all relevant thematic areas; for example, strategies for discussing sexual development fit both the healthy sexual development and communication themes. The product of this distillation was over 30 pages of content, activities, and handouts. Because the goal was to create a concise, one session module, further refinement and distillation was done under the advisement of an expert curriculum developer. This resulted in the

reorganization of thematic areas to three components: healthy sexual development, parent-child communication, and safety. The curriculum developer streamlined the content into a provider's structured session guide to teach parents skills (Provider Guidebook) and a companion guide for parents (Parent Handbook).

Phase 2: Rapid Prototyping & Development of Assessment Tool

At the end of Phase 1, we had a draft curriculum designed to add CSA prevention content to existing PE programs (hereafter referred to as Version 1). This material, though driven by input of experts, parents, and providers needed refinement and validation. To do this in an efficient manner, we utilized *rapid prototyping*, an iterative method borrowing from human-centered design, in which versions of the curriculum are tested out with end-users, feedback is obtained, revisions are made, and the process is repeated (Liedtka & Ogilvie, 2011). In contrast to typical intervention development where an intervention is developed and feedback is solicited on the whole, rapid prototyping introduces feedback more frequently so as to refine content, delivery, or presentation in a time efficient manner. Intermittent feedback is a valuable strategy in curriculum development; the curriculum and materials are created within a context that meets the needs and capabilities of the end-user (Harte et al., 2017; Waterman, Small, Newman, & Steich, 2016). The process eliminates the number of modifications once the intervention is rolled-out or scaled-up. Rapid prototyping is complete when end-user feedback offers no new ideas for program enhancement. We also needed to create an assessment tool to be used in further evaluation of the module. The objective of Phase 2 was threefold: (a) to rapid prototype Version 1 of the parent handbook with parents and providers; (b) to solicit provider feedback on Version 1 of the provider materials; and (c) to develop and conduct a psychometric evaluation of an analytic measure.

Parent Rapid Prototyping

Method.—Three 90-minute group sessions were conducted with three individuals recruited from the community (2 males, 1 female) with children between 2 and 9. Each of the sessions was devoted to one core component: healthy sexual development, parent-child communication, or safety. Parents took turns reading aloud sections and were invited to offer feedback, ask questions, and provide suggestions on the input on the presentation, specific content, and general flow of the handbook. In addition to participant-generated discussion, researchers asked participants predetermined questions raised by the development team (e.g., “What are some examples of how to correct inappropriate language or behaviors?”). Participants were compensated \$50 for their time. Participants' comments were compiled and a marked-up version of the parent handbook was sent to the curriculum developer, who revised and created Version 2 with the goal of streamlining presentation and incorporating suggestions.

Version 2 of the handbook was subjected to rapid prototyping with 13 novel parents of at least 1 child under 18. In 60 minute meetings, three parents provided feedback on one of the three components (i.e., healthy sexual development, parent-child communication, and safety) such that feedback on all components of the Version 2 curriculum were collected in three hours and quickly sent to the curriculum developer. Version 3 was then distributed to

three novel parents and followed the same procedure. We repeated this process four times (three rounds of three, one round of four parents) until we reached a point where comments and suggestions were exhausted. Participants were compensated with a \$25 for their one-hour session.

Results.—Participants from the group sessions conducted with Version 1 in the first round of rapid prototyping provided suggestions related to the handbook generally, including presentation (e.g., how to break up “walls of text”, brief summary sections, improvements to the visuals), flow (e.g., how to meaningfully divide child age groups), and language (i.e., phrasing, the reading level). The groups offered a number of specific comments (e.g., include discussion of masturbation in young age groups) and participant examples of experiences with their own children (e.g., “Do not touch your brother’s penis even though you think it is funny”). For example, there was a discussion regarding the concept of privacy when using the bathroom for children 3–5 years old. Although this group of parents agreed that 3-year-olds are generally too young to use the toilet alone, and are too young to go to the bathroom on their own in a public place, the concept of privacy can be instilled in children this age by teaching them to respect *others’* boundaries when using the bathroom. Another discussion among these participants centered on children’s knowledge of sexual language (e.g., slang) versus use of such language: for example, knowing that “dick” refers to “penis”, but not using “dick”. Two of the participants expressed conflicted feelings about wanting their children to know what such words mean, but not wanting them to say them. There was discussion about the appropriate age for children to know these words and how children will hear them (e.g., on the bus from peers or older children).

Version 1 of the parent handbook was revised so as to reduce wordiness and large blocks of text were removed or rearranged such that images broke up the “walls of text.” Sections were rewritten if the wording sounded too “academic” or “awkward” for parents. Following the suggestion of the group of parents, summaries of key messages were added to the end of each segment; age groups were adjusted to coincide better with grade-level changes (e.g., elementary, middle school, high school); segment symbols were added such that parents could more easily refer to various portions of the handbook; and some concepts (e.g., masturbation) were emphasized more strongly in the revision.

In the second round of rapid prototyping, beginning with Version 2 of the handbook, parents participated in individual sessions and provided their feedback on specific sections of the revised parent handbook. Parents in this round had similar comments to those heard with Version 1 related to the general visualization, flow, language. Small tweaks to presentation and wording continued until all comments were addressed and at the conclusion of this round of rapid-prototyping, Version 5 of the parent handbook was created alongside an accompanying activity book and provider guidebook.

Provider Rapid Prototyping

Method.—We prioritized parent participation in Phase 2 of this research so as to maximize its acceptability among the end users. We believed it was imperative to get parent materials in optimal presentation before developing the provider materials that would teach parents

those skills. The second objective of Phase 2 was to obtain provider feedback on Version 5 of the parent handbook, its accompanying provider guidebook and activity book among those trained to deliver a PE program. Six providers (100% female) who were trained in multiple PE programs were recruited from a local parent-education program service agency and participated in a 2-hour rapid prototyping session as a group so as to maximize input by allowing for discussion amongst providers. Participants reviewed (a) Version 5 of the parent handbook, (b) the provider guidebook, which contained much of the same content as the parent handbook, but served as a session guide with suggested language for relaying information to parents, and (c) an accompanying activity book containing role-play scenarios and activities to practice protective skills with parents. The goal of this rapid prototyping round was to improve the script providers would use to relay information to and facilitate discussion with parents as well as to assess the usability of the handbook and functionality of the activity book. Participants took turns reading aloud sections of the provider handbook while reviewing the accompanying parent handbook and activity book. Participants were compensated with a \$50 e-gift card for their two-hour session.

Results.—A substantial portion of the group interview centered on the introduction of the curriculum. The providers thought it important to make sure the parents did not feel as though the provider was there to “pry” into their family life or history (i.e., not to accuse the parent or suggest that their child had experienced CSA), but instead to take a strengths based perspective conveying the importance of protecting children from harm. Providers thought it unnecessary to convey specific potential barriers to learning about CSA in the event that it might bring up concerns that the parent did not actually have. For example, by suggesting that some parents may be concerned about their children being too young to hear about sexual topics, a parent might become concerned about this despite not having that concern prior to hearing the potential barrier. Similarly, it was suggested the provider handbook have an introduction, or “conversation starters”, for each of the components.

Providers offered feedback on the layout of the provider handbook and activity book as well as suggestions for improving the usability of both documents in individual- and group-delivery formats. Because not all providers would be familiar with a manualized curriculum, this group of providers suggested enough detail be included in the script for providers to rely on until they became familiar with the material. Providers were enthusiastic about the inclusion of follow-up questions (e.g., “how likely are you to respond like this to your child?”) included after each role-play from the activity book as a way to further discuss the scenario with their parents. Providers scrutinized terminology in the curriculum. For example, providers thought parents might not be familiar with the term “vetting” in the context of finding and interviewing potential caregivers. The providers asked for suggestions of different ways to explain this concept in the curriculum for those parents who did not understand its definition at first. Finally, providers suggested it would be burdensome to navigate to the between the different sections of the guidebook and a corresponding activity in the activity book. Though they liked the activity book for presentation, in practicality, the thought of juggling two documents in the chaotic home environment was impractical.

In general, the providers were enthusiastic about the presentation of the material, the relevance of the content for the clients on their caseload, and their interest in delivering the

curriculum. The curriculum developer took these suggestions and revised version of the curriculum to be tested in an acceptability and feasibility pilot. We integrated the role-play scenarios from the activity book into the parent and provider materials, such that there was only one document for the provider and one document for the parent. From the input following this phase of rapid prototyping, we made Version 6 of the parent handbook and Version 2 of the provider guidebook that would be used in the subsequent phase of research. Providers suggested we give the curriculum a name that was supportive of parents, but that did not immediately signal the content area. Under these constraints, the research team selected the name *Smart Parents – Safe and Healthy Kids* which was used in the acceptability and feasibility pilot (Phase 3).

Parent Assessment Tool: Psychometric Evaluation

Method.—Based on Version 5 of the parent handbook, the research team generated questions designed to assess the knowledge, attitudes, and protective behaviors taught in the curriculum. The development was informed by existing measures used to assess knowledge, attitudes, and behaviors regarding CSA prevention, including a behavior change questionnaire (Burgess & Wurtele, 1998), the Child Sexual Abuse Myth Scale (Collings, 1997), and a preventive behaviors questionnaire (Wurtele et al., 2008). The 20-item assessment was comprised of 16 questions rated on a 5-point Likert scale (strongly disagree to strongly agree). Eight items assessed parents' knowledge of general facts about CSA (e.g., "Most sexual abuse victims are abused by someone they know") and sought to ascertain parents' attitudes regarding their role in CSA prevention (e.g., "As a parent, I am the best person to teach my child about preventing sexual abuse") and what is appropriate to discuss with children (e.g., "The only time a parent should talk to their child about sex is when he/she reaches puberty"). Behavioral questions (7 items) assessed parents' current behaviors regarding CSA prevention (e.g., "I have talked to my child about how to protect him/herself from being sexually abused"). In addition, four hypothetical scenarios assessing protective behaviors were developed to assess parents' behavioral response to situations where CSA either has or is likely to occur. Research suggests the utility of hypothetical scenarios (i.e., indirect observation) for understanding how individuals might behave in real-life situations (Gould, 1996; Hintze, Stoner, & Bull, 2000; Hughes & Huby, 2002). In particular, it has been suggested that scenarios may be especially useful for understanding individuals' responses to rare or controversial events (Barter & Renold, 2000; Ulrich & Ratcliffe, 2007). Including hypothetical scenarios that require a behavioral response is important for assessing beyond parents' knowledge and attitudes. In these scenarios (see Figure 1), parents identified the proper response to a hypothetical situation in which CSA likely had or would occur. Scenarios described situations ranging from ambiguous (e.g., a child tells her parent she does not like the babysitter) to more obvious (e.g., a child discloses that an adult touched his private parts); response choices generally included options for inaction, directly confronting the suspected party, and calling the authorities (the police and/or ChildLine, the statewide child abuse referral registry managed by the Pennsylvania Department of Human Services).

Using a convenience sample and snowball recruiting methods, 61 parents with at least one child under 18 completed the assessment during the rapid prototyping sessions ($n = 13$) or

through an online survey ($n = 48$). Participants were primarily female (77%), white (90%), employed full-time (74%), and the average age was 36.5 years (range: 30–49). Nearly all of the participants (97%) were college-educated; 41% were college graduates and 56% had an advanced degree. Participants who completed the survey during a rapid prototyping session were not compensated beyond the \$25. Those who completed the survey outside of the rapid prototyping session (i.e., these participants only completed the survey) were compensated \$10.

Results.—The distribution of items was assessed through PROC FREQ. Two items with no variance were eliminated from the factor analysis conducted using PROC FACTOR in SAS® 9.4. Promax (oblique) rotation to an Equamax target was used to maximize simple structure. A scree plot of the eigenvalues indicated a two factor solution: “Knowledge and Attitudes” (8 items, $\alpha = .68$) and “Behaviors” (4 items, $\alpha = .75$). Table 1 contains the factor loadings for the resultant tool, the Assessment of SmartParents’ Knowledge questionnaire. Factor loadings in bold are hypothesized and/or theoretically sound, whereas those underlined are dual and/or secondary hyperplane loadings. The number of hyperplane loadings was sufficiently low and the two factors were minimally correlated ($r = 0.31$, $p < .31$) relative to alpha coefficients suggesting factor independence. The two factors account for 99% of the variance. Negatively worded items are to be reverse-coded, such that higher scores indicate greater knowledge or more positive attitudes or behaviors. Three new questions regarding behaviors were added to fortify Factor 2 so that it would be comparable to Factor 1 in terms of the number of items. The resultant assessment at the end of Phase 2 was comprised of 15 items on a 5-point Likert scale and 4 multiple-choice scenarios. In future phases of our research, the vignettes will be evaluated for construct validity and the 15 items be subjected to further psychometric evaluation.

Phase 3: Acceptability and Feasibility Pilot

The *Smart Parents – Safe and Healthy Kids* module is designed to help parents (a) learn about typical sexual development; (b) know how to talk with their child about sexual topics throughout childhood; and (c) reduce the risk for sexual victimization of their child by creating a protective environment by practicing supervision and monitoring. These objectives are accomplished through three segments with distinct goals (Table 2). Ultimately, the implementation of the module will be provided by providers of existing PE programs. In the *Smart Parents – Safe and Healthy Kids* session, providers utilize a Guidebook to provide a combination of didactic information, modeling, and role-playing with feedback to convey the information for each segment. Parents are provided a companion Handbook that includes the didactic information and interactive activities written at or below an 8th grade reading level. The didactic information includes ‘call out’ boxes that emphasize key points; the parent is directed to the text for more information. During the session parents are encouraged to take notes and write down answers to activities within the Handbook. The information and activities for each segment are organized into distinct age categories (birth–2, 2–5, 6–8, 9–12, 13 and older) following other development-oriented curricula. The curriculum comprehensively provides content for ages 0–13 so parents can access information as their child ages or if they have a younger child.

The objective of Phase 3 was to pilot *Smart Parents – Safe and Healthy Kids* so as to (a) determine the feasibility of delivering the module within one additional session of three existing evidence-based PE programs and (b) assess the acceptability of the content and presentation among parents and providers. The pilot work did not seek to test hypotheses, but instead was designed to inform future empirical research. *Smart Parents – Safe and Healthy Kids* was designed to be added into any evidence-based PE program. However, to establish an evidence base and empirically examine the additive approach, we limited our pilot to three evidence-based PE programs. Selected based on modality (e.g., home visit vs. group setting) and target age (e.g., birth to five vs. 2–12 years old), the acceptability and feasibility pilot was conducted among parents who received and providers who delivered SafeCare (Guastafarro, Lutzker, Graham, Shanley, & Whitaker, 2012), Parents as Teachers (Albritton, Klotz, & Roberson, 2003), and Incredible Years (Reid & Webster-Stratton, 2001). For practical reasons, the module was delivered by a member of the research team. Additionally, the Assessment of SmartParents' Knowledge, which will be used in future research as an outcome measure, was delivered to participating parents so as to estimate baseline responses to these questions among parents enrolled in PE programs. Phase 3 was complete following the implementation of the *Smart Parents – Safe and Healthy Kids* curriculum with parents. The product at the conclusion of Phase 3 was a finalized provider guidebook and parent handbook.

Method

Participants and setting.—Providers of the three PE programs were asked to distribute a flyer describing the opportunity to participate in one additional session. Parents were eligible to participate in the research if they were 18 or older, a parent to at least one child under 18, and completed typical implementation of one of the three PE programs. Five parents who had recently completed the individually-delivered PE programs – SafeCare and Parents as Teachers–agreed to participate. The individual SPSHK sessions were conducted in the homes of participants when the children were home, as is done in typical implementation. A total of 19 parents from 3 groups that had recently completed all training sessions of Incredible Years agreed to participate. The group -based *Smart Parents – Safe and Healthy Kids* sessions were conducted in a classroom at a local community-serving organization. No demographic data were collected on these participants ($N = 24$).

Procedure.—Parents completed a baseline assessment of CSA knowledge, attitudes, and behaviors using the Assessment of SmartParents' Knowledge at the beginning of the *Smart Parents – Safe and Healthy Kids* sessions. Parents could skip any question they did not wish to answer. A member of the research team then delivered the *Smart Parents – Safe and Healthy Kids* curriculum. In the individual deliveries of the module, the activities focused on the age of the participant's child who was the original focus of the parenting program. In the event a parent had multiple children, activities for all applicable age groups were reviewed. In the group deliveries, each relevant age group was reviewed for each activity; the “volunteer” parent rotated, and parents only did the activity for the age of their child or in the next oldest age group.

At the conclusion of the session, parents completed a 10-item satisfaction in which they were asked to rank the degree to which they agreed (1 = *strongly disagree* to 5 = *strongly agree*) with statements regarding the materials (e.g., “It is easy to find what I need in the parent handbook”), utility of the content (e.g., “I believe that this training would be useful to other parents”), mechanisms of training (e.g., “The role-play scenarios during the session helped me become more at ease with CSA-related topics”), and their provider (e.g., “The provider was good at explaining the information”). Parents had the opportunity to provide any additional comments in a narrative format. Parents also completed a 10-item acceptability survey, adapted from Ben-Zeev et al. (2014), on which they were asked whether to what extent they agreed or disagreed with 5 statements about the handbook (e.g., “Most people could learn to use the parent handbook,” “It is easy to find what I need in the parent handbook”) and 5 statements about the session or the session provider (e.g., “The length of the session was okay,” “The provider who led my session was responsive to my questions and comments”). An open response field was provided for parents to share their favorite and least favored aspects of the session. The duration of sessions ranged from 75–90 minutes and all parents were compensated \$50.

The *Smart Parents – Safe and Healthy Kids* sessions were delivered by a member of the research team and observed by the providers of the parent-education programs ($N = 9$). Each provider was given a copy of the provider guidebook to follow along during the session. Providers were asked to complete a 6-item open-ended questionnaire about their opinion of the module prior to (“Before you came today, what did you think about adding an additional session to the curriculum you already deliver?”) and following their observation of the implementation (“How did your thoughts on delivering the additional session change as we went through [it]?”), as well as suggestions regarding presentation, pacing, and content (e.g., “Could the material be presented differently? If so, how?”). Providers were given the questionnaire as they observed the implementation so that they could write their comments as they came up in the session so as to maximize their real-time input on the acceptability and feasibility of the *Smart Parents – Safe and Healthy Kids* curriculum. All providers were compensated \$50.

Results

Assessment of SmartParents’ Knowledge Descriptive Statistics.—Twenty-three participants completed the baseline assessment (Table 3). The mean score for the Knowledge and Attitudes factor was 4.17 ($SD = .53$; Range: 3.13–4.88); higher scores indicate greater knowledge about CSA (e.g., knowing most sexual abuse victims are abused by someone they know) and reflect more positive attitudes regarding CSA prevention strategies (e.g., teaching children the correct names for private parts). Most parents (56.5%) strongly agreed that it is okay if a child does not want to hug an adult, and that it is okay to ask for a background check for a new babysitter (91.3%). The mean score for the Behaviors factor was 3.56 ($SD = .64$; Range: 2.43–4.86). Higher scores for these items indicate that a parent may be more likely to engage in effective CSA prevention strategies (e.g., talking to children about CSA). The majority of parents (76.2%) reported that they have talked to their child about what to do if someone tries to hurt him/her. Parents responded to the scenarios by selecting what they believed to be the single correct response (Figure 1; the correct response

circled). Fifteen percent of parents correctly answered the first scenario; the most common error (69.6%) was the choice to confront the uncle in addition to the correct response of calling ChildLine and reassuring the child. The majority of parents correctly answered the second and fourth scenarios, 68.2% and 82.6%, respectively. In contrast, only 4.3% correctly answered the third scenario; the most common error was to select the option in which both ChildLine and the police were called. These data demonstrate the responses typical of parents enrolled in PE programs. The Assessment of SmartParents' Knowledge will be subjected to a confirmatory factor analysis in the future, when more individuals have completed the finalized assessment in subsequent phases of research.

Parent satisfaction and approval.—After completing *Smart Parents – Safe and Healthy Kids*, more than 70% of parents agreed that talking with their child about sexual abuse prevention would be easier in the future, and 88% thought the training would be useful to other parents. Only one parent did not feel that the training provided them with new or useful information or skills. In open response, parents specifically highlighted the participatory nature, “reading out loud and doing role-play,” of the curriculum. One parent wrote: “I liked that we [discussed] ways to talk over the topics with our kids.” All parents agreed the session was helpful and the handbook was easy to read, and they expressed confidence they could use the handbook on their own. Over 90% of parents felt the handbook contained both clear and consistent information and that most people could learn to use it. All but two parents said they would recommend the handbook to a friend. More than 90% of parents found the length of the session to be acceptable and perceived the SPSHK provider to be prepared, knowledgeable, and responsive.

Provider satisfaction and approval.—Providers were asked to describe their initial thoughts about adding an additional session to the PE program they already deliver, prior to their observation of the added session. The majority of providers felt unsure about adding an additional session to an “already quite full” curriculum. One provider stated, “The program is already full of useful and important information.” The providers shared concerns about the added session being misaligned with the content of the parenting program: “I was apprehensive about it given the content of what was being delivered. I felt that it was not fair to participants as they signed up for parenting class and this did not seem to fit with that.” Skepticism was also shared regarding the subject matter: “I was also concerned that it may trigger individuals who have a history of childhood abuse.” However, all providers expressed a marked change of opinion regarding the additional session as they observed the delivery of the module. One provider wrote, “My thoughts changed completely. The content was extremely beneficial to parents of kids of all ages. And [it] is taught in a very practical, non-threatening way. All parents need to know this information and I understand more fully how it is very appropriate for a parenting class.” Another provider shared that the material “was not what I expected. I think that this topic fits very well into the program,” and yet another provider said she “would be happy to deliver the module.” A common concern among a majority of providers was the pace: “I think there was a lot to cover, but the pacing did seem pretty appropriate. [It felt] maybe slightly rushed to get through it all.” One provider suggested that she would want to follow up on the material discussed during other visits with clients. When asked if there was anything missing from the curriculum, the seven

providers agreed that the curriculum was inclusive and did not offer new material to be covered.

Discussion

Although the prevalence rate of CSA has declined steadily since the 1990s (Finkelhor, Saito, & Jones, 2016), the mechanisms leading to the decline in prevalence is not well understood (Lutzker, Guastaferrero, & Whitaker, 2014). Primary prevention efforts to eradicate CSA are critical to staving off the deleterious short- and long-term consequences for victims of sexual abuse. However, primary prevention efforts targeting adults in the community or school-aged children have not adequately affected rates of CSA (Letourneau et al., 2014). A comprehensive prevention approach—that is, one targeting all members of the community—is necessary. In current CSA preventions a key prevention target is often overlooked: parents. General PE programs have documented a decline in rates of neglect and physical abuse (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012; Webster-Stratton & Reid, 2010); however, these PE programs are not affecting rates of CSA specifically. It is not necessarily the case that yet another PE program is needed. Instead, it may be sufficient to add-on a CSA-focused prevention module to existing evidence-based PE programs.

Leveraging the wealth of evidence-based PE programs available, we sought to develop a brief parent- focused CSA prevention module that could be added onto existing PE programs in one additional session. Building upon the core parenting skills common among general PE programs (Guterman, 1999), our module would enhance those skills by providing specific CSA prevention content. We approached the development of this intervention approach through three phases. In Phase 1, we solicited input from experts, providers, and parents and compiled this information alongside content from existing CSA programs. The most challenging aspect of this phase was eliminating content from the curriculum; we wanted our curriculum to be delivered within one session, so distilling the information into essential elements was a key activity of this phase. Our team elected to hire an expert curriculum developer during this phase to guide the organization of content and presentation of material for adult learners— a strongly recommended tactic for any intervention scientist developing an intervention, especially one consolidating information from multiple sources.

The structured session guide for providers and companion document for parents was refined through a process of rapid prototyping in Phase 2. Borrowed from human centered design methods, rapid prototyping involved obtaining participant feedback on sections of the curriculum, using feedback to guide revisions, then obtaining feedback from another participant. This iterative process, in conjunction with the addition of an expert curriculum developer to our team in Phase 1, allowed for swift modification to the curriculum. Simultaneously, we conducted a preliminary psychometric evaluation of a measure designed to assess the effect of the module. Refinement of both the curriculum and assessment at the same time assured that the two were in agreement and maximized participant input. The formative work in Phase 2 resulted in a complete curriculum, *Smart Parents – Safe and Healthy Kids*, which includes a comprehensive Parent Handbook and a companion Provider Guidebook complete with role -playing activities.

Phase 3 sought to examine the acceptability of *Smart Parents – Safe and Healthy Kids* among parents enrolled in three PE programs and their providers. Parents were overwhelmingly enthusiastic about the curriculum, the majority saying that they felt discussions in the future regarding sex and sexual abuse would be easier. Providers who observed the session in which *Smart Parents – Safe and Healthy Kids* was delivered were also asked their opinions about acceptability. Notably, the providers, who were initially skeptical of adding more content to the PE program, were enthusiastically supportive of the content and presentation of material. Obtaining written feedback such as this is important in preparing for future research on the module; we will be able to share the sentiment of these comments as a means of building provider buy-in. Another goal of this phase was to examine the feasibility of delivering the material in one session. Session time varies by program: Incredible Years sessions are 120 minutes in duration, whereas Parents as Teachers and SafeCare visits are closer to 60 minutes in duration. Participants were not made aware of this objective explicitly, but it was an important feature of this phase that has important implications for future research with *Smart Parents – Safe and Healthy Kids*.

Our three-phase approach ultimately produced a product that is acceptable to parents and providers, which is most important as they are the ultimate benefactors and purveyors of our work. It is a product that is ready for empirical evaluation, but the process is not without limitations. A potential limitation of our approach in Phase 1: Content Development was that the sample of parents and providers interviewed were not representative of all parents or providers. A wider sample might have been more representative, but because we reached saturation in our interviews, we were comfortable with the directions in which the interviews led us. A limitation of our approach in Phase 2: Rapid Prototyping was the segmentation of the curriculum, such that participants only saw a portion of the curriculum at a time. The rationale for this approach was to have the curriculum developer modifying one segment of the curriculum as other members of our team conducted the rapid prototyping sessions with families. Additionally, the purpose of Phase 2 was not to ascertain the efficacy of the curriculum. Related, in the psychometric evaluation conducted in Phase 2 we did not collect demographic information for all of these participants, and therefore we cannot guarantee the representation of our sample which impacts generalization. This will be important to examine in future research on the module. Finally, the design of this Phase 3: Acceptability and Feasibility did not allow for a baseline assessment in advance of the session (i.e., at least one week before) or contact with the participant after the session. As such, we did not have participants complete a post-intervention assessment. While this is a small limitation and perhaps missed opportunity to better understand the effectiveness of the module, it was not the purpose of this Phase of research.

Smart Parents – Safe and Healthy Kids fills an important niche that is missing from current CSA prevention efforts. More importantly, the additive approach we used in which the module is added as one additional session to existing PE programs is an innovative way to leverage the foundational parenting skills learned in and the implementation infrastructure of the PE program. This approach maximizes participant engagement while simultaneously building in the sustainability of *Smart Parents – Safe and Healthy Kids*. The additive approach not only creates substantive lines of inquiry for future research, such as the effectiveness of this approach enrolled in additional PE programs, but also methodological

lines of inquiry. For example, future research should examine the effectiveness of this approach among parents enrolled in additional PE programs and examine the long-term effect of the module, especially as children transitions between developmental stages. Overall, by leveraging the basic parenting skills and implementation infrastructure of existing PE programs, an added CSA focused module to existing PE programs can provide a novel, efficient, impactful, and sustainable prevention strategy that affects rates of CSA.

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List of abbreviations

CSA	Child sexual abuse
PE	Parent-education
SPSHK	Smart Parents – Safe and Healthy Kids
ASK	Assessment of SmartParents’ Knowledge
RCT	Randomized controlled trial

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For the following scenarios, please select the correct response.

Scenario 1:

Mary's 5-year-old son, Billy, came home from spending the weekend camping with his uncle. Billy told his mother that his uncle touched his penis and it made him feel yucky. What should Mary do?

- ☐ A) Confront the uncle about his behavior
- ☐ B) Call ChildLine
- ☐ C) Thank Billy for telling her and tell him it is not his fault
- ☒ D) Both B and C
- ☐ E) A, B, and C

Scenario 2:

7-year-old Stephanie suddenly started acting nervous around her babysitter. She wets the bed at night, and throws temper tantrums when her father leaves her alone with the babysitter. What should the father do?

- ☐ A) Accuse the babysitter of sexually abusing his daughter
- ☒ B) Ask Stephanie why she is uncomfortable around the babysitter
- ☐ C) Call ChildLine
- ☐ D) Call the police
- ☐ E) All of the above

Scenario 3:

Nicole's high school math teacher showed her an inappropriate video of two adults having sex. Nicole told her mother about the video. What should Nicole's mother do?

- ☒ A) Call ChildLine
- ☐ B) Accuse Nicole of lying
- ☐ C) Call the police
- ☐ D) Do nothing
- ☐ E) Both A and C

Scenario 4:

John's 12-year-old son, Doug, is spending a lot of his free time on the Internet on the family computer. John found out that his son was visiting chat rooms where adults were sending nude photos of themselves to his son. What should John do?

- ☐ A) Call ChildLine
- ☐ B) Talk to Doug about his use of the Internet
- ☐ C) Put the family computer in a public room
- ☒ D) All of the above
- ☐ E) Do nothing

Figure 1.
Scenarios.

Table 1

Rotated Factor Pattern of 14 Child Sexual Abuse Prevention Items Composing Two Factors

Factors: Item Content	Knowledge and Attitudes	Behaviors
<i>Factor 1: Knowledge and Attitudes</i>		
Children should be taught the correct names for their private parts.	.297	.055
Most sexual abuse victims are abused by someone they know.	.649	.114
The only time a parent should talk to their child about sex is when he/she reaches puberty.	.395	.118
It is okay if my child does not want to hug an adult, such as a family member.	.469	.193
My children might become sexually active because I talk to them about sex.	.674	.077
I know what healthy sexual development is.	.646	.073
It is okay to ask for a background check for a new babysitter.	.366	.069
Children should learn about how to prevent sexual abuse only in schools.	.200	.043
<i>Factor 2: Behaviors</i>		
Child sexual abuse is a serious problem that only the police should handle. I do not need to be involved.	.089	.443
I know what signs to look for that suggest my child may have been sexually abused.	<u>.323</u>	.454
I have talked to my child about how to protect him/herself from being sexually abused.	.050	.833
My child and I have talked about what to do if someone tries to hurt him/her.	.079	.850

Note. Hypothesized factor loadings (standardized regression coefficients) are in bold, hyperplane loadings are underlined.

Table 2

Segment Goals for the Smart Parents – Safe and Healthy Kids Curriculum

Segment	Segment Goal	
Healthy Sexual Development	1	Increase parents' knowledge of healthy sexual development.
	2	Increase parents' knowledge of problematic and abusive sexual behaviors.
	3	Increase parents' ability to communicate developmentally appropriate sexual information.
Parent-child Communication	1	Increase parents' knowledge of how to talk with their child about sexual topics.
	2	Increase parents' ability to routinely check in with their child.
	3	Increase parents' knowledge of personal boundaries and how to encourage boundaries with their child.
Child Safety	1	Increase parents' knowledge and actions to monitor child's activities and interactions with others.
	2	Develop a child safety plan.
	3	Increase parents' knowledge of what to do if s/he suspects a child has been abused and/or if child discloses abuse.

Table 3

Assessment of Smart Parents' Knowledge Descriptive Statistics for the Acceptability and Feasibility Pilot of the Smart Parents – Safe and Healthy Kids Module (N=23)

Item	Mean	(SD)	Strongly Disagree (1)	Disagree (2)	Neither Agree Nor Disagree (3)	Agree (4)	Strongly Agree (5)
<i>Factor 1: Knowledge & Attitudes</i>							
Children should be taught the correct names for their private parts (e.g., penis, vagina).	4.00	(0.95)	--	8.7%	17.4%	39.1%	34.8%
Most sexual abuse victims are abused by someone they know.	4.13	(1.18)	4.4%	8.7%	8.7%	26.1%	52.2%
^a The only time a parent should talk to their child about sex is when he/she reaches puberty.	3.95	(1.25)	50.0%	13.6%	22.7%	9.1%	4.6%
It is okay if my child does not want to hug an adult, such as a family member.	4.52	(0.59)	--	--	4.4%	39.1%	56.5%
^a My children might become sexually active because I talk to them about sex.	4.17	(0.89)	47.8%	21.7%	30.4%	--	--
I know what healthy sexual development is.	3.57	(1.12)	8.7%	4.4%	26.1%	43.5%	17.4%
It is okay to ask for a background check for a new babysitter.	4.91	(0.29)				8.7%	91.3%
^a Children should learn how to prevent sexual abuse only in schools.	4.22	(1.35)	69.6%	4.4%	13.0%	4.4%	8.7%
<i>Factor 2: Behaviors</i>							
^a Child sexual abuse is a serious problem that only the police should handle. I do not need to be involved.	4.50	(0.60)	54.6%	40.9%	4.6%	--	--
I know what signs to look for that suggest my child may have been sexually abused.	3.35	(0.83)	4.4%	4.4%	47.8%	39.1%	4.4%
I have talked to my child about how to protect him/herself from being sexually abused.	3.18	(1.26)	9.1%	18.2%	40.9%	9.1%	22.7%
My child and I have talked about what to do if someone tries to hurt him/her.	3.95	(1.16)	4.8%	9.5%	9.5%	38.1%	38.1%
^a I do not know what signs to look for that suggest my child may have been sexually abused.	3.48	(1.08)	17.4%	30.4%	43.5%	--	8.7%
^a I have not talked to my child abuse sexual abuse.	2.86	(1.25)	13.6%	13.6%	31.8%	27.3%	13.6%
^a My child and I have not talked about what to do if someone tries to hurt him/her.	3.59	(1.22)	31.8%	18.2%	31.8%	13.6%	4.6%

Note. Means and standard deviations reflect final item values after transformation where necessary. Frequencies reflect the raw score.

^aItem reverse-coded