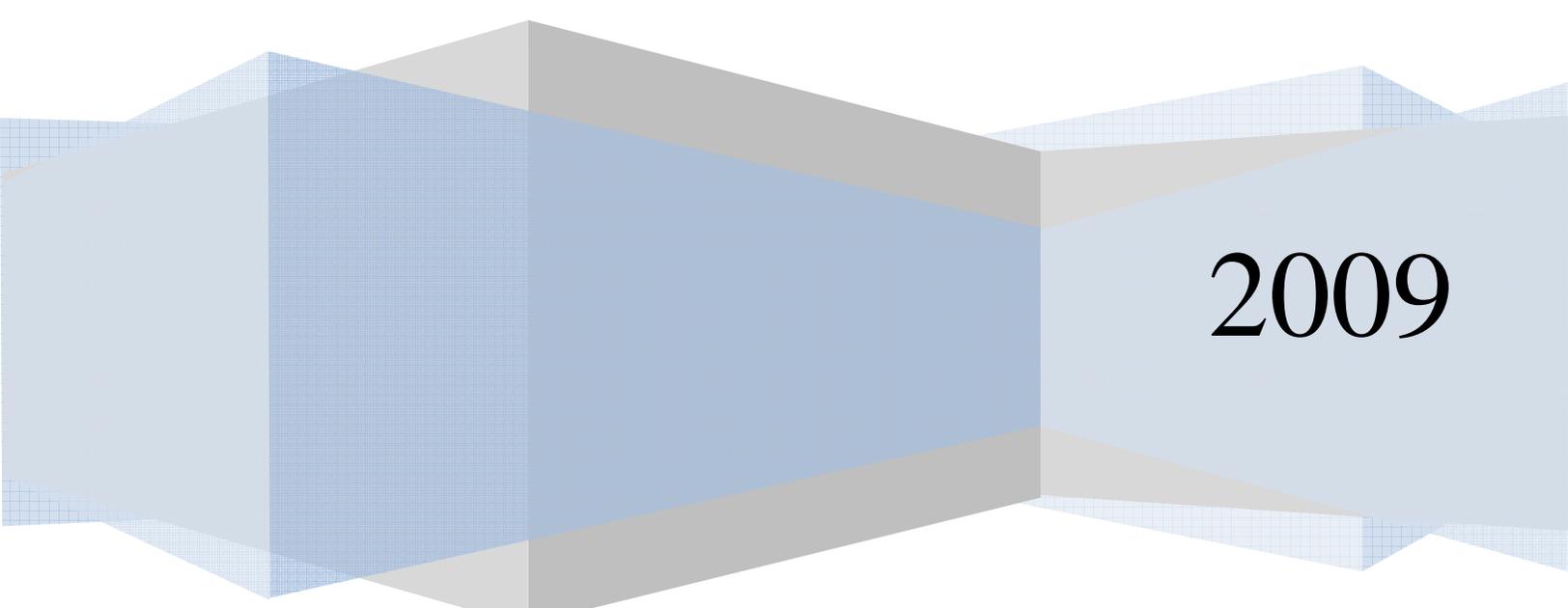


Prevent Child Abuse Iowa

**Evaluation of the  
*Nurturing Healthy Sexual  
Development Program: A  
Comparison of  
Individually and Group  
Administered Conditions***

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## **Abstract**

In recent years, efforts to prevent child sexual abuse have been expanding beyond an emphasis on child-focused programs to facilitating meaningful involvement of adults in keeping children safe. The impetus for this study was to examine the potential feasibility and effectiveness of a parent-focused program in Iowa which would shift emphasis from children having responsibility for their own safety to encouraging adults to take the lead.

This study evaluated a parent-focused child sexual abuse prevention intervention (Nurturing Healthy Sexual Development Program) providing instruction in a home-based (n=55) or group form (n=48). The study also used a control group of parents (n=55) in programs that provided parenting instruction as usual (e.g., education on child development, positive discipline, and communication) but without the sexual abuse educational component. Counties receiving funding from Prevent Child Abuse Iowa were matched with communities comparable to the extent possible for purposes of comparison. Results indicated that there were some significant differences between groups on scales measuring gaining factual information and the ability to identify concerning sexual behaviors in children. However, the importance of this finding is reduced by a finding that the groups were not equivalent regarding the original matching intention. Although overall scale differences reflected some differences based on condition, an examination of individual survey items provided the most comprehensive information. Significant gains were noted in a few fact items and one action item by the control group. However, significant gains were made on three to four times as many items for the individual and group conditions. Further, although the demographics of the participants were not equivalent in each group, nonetheless both treatment conditions made significant gains in identifying concerning child sexual behaviors, learning facts, and willingness to take action from pretest to posttest.

## **Organizational Context**

Prevent Child Abuse Iowa (PCA Iowa) has the mission of ending child abuse in the entire state of Iowa. PCA Iowa believes that most parents love their children, wish to be good parents, and do not want to abuse their children. Nonetheless, some parents are socially isolated, have few resources to help in difficult times, face stresses with which they cannot cope, and/or lack important parenting skills. Parents with these challenges are often at greater risk of abusing their children.

Since 1975, PCA Iowa has provided services to families to assist them to receive the social support, respite child care, and education they need so that children are safe from abuse and neglect. Toward that end, PCA Iowa currently directs two child abuse prevention programs that annually help 15,000 parents and 65,000 children in more than 90 Iowa counties. The agency also informs and educates decision-makers, professionals, the media, and the public about child abuse and how to prevent it. Finally, PCA Iowa advocates before legislative and administrative officials for expanded child abuse prevention services.

While it seeks to end all forms of child abuse and neglect, PCA Iowa has focused more of its efforts recently on the prevention of child sexual abuse. This greater focus on child sexual abuse reflects heightened public concern over the need to prevent this serious harm to children. PCA Iowa's recent sexual abuse prevention efforts have included: identifying best practices for child-focused sexual abuse prevention instruction, highlighting strategies for engaging parents

and other adults in preventing child sexual abuse, training practitioners on new prevention curricula directed at educating adults, and advocating for increased legislative funding for sexual abuse prevention instruction.

Protecting Iowa's children from sexual abuse is an issue that has received much recent legislative attention. In 2007, this legislative debate resulted in a substantial increase in appropriations (\$200,000) for PCA Iowa's child sexual abuse prevention programming. PCA Iowa used a significant portion of this additional funding to establish a statewide effort to educate parents and other adults on how to protect children from sexual abuse. The adult education program, *Nurturing Healthy Sexual Development*, includes use of a detailed 24-page booklet, covering child sexual development by age, concerning behaviors exhibited by children, and how and when to report suspected abuse. The program, developed by Prevent Child Abuse Vermont, teaches adults, particularly parents, about sexual abuse – including informing them that the primary risk for abuse comes from adults known to the family. The instruction also helps parents and other adults identify the actions they can take to protect children from sexual abuse. This is the program that was evaluated by this research team.

PCA Iowa's new program represents a significant shift in the focus of child sexual abuse prevention efforts. To this point, the primary audience for sexual abuse prevention instruction in Iowa and most other states has been children, not adults. PCA Iowa's new adult-focused instructional initiative recognizes that adult protection is critical to making even well-informed children safe from the risks of sexual abuse.

At the time of this evaluation, PCA Iowa funded projects in almost 60 of Iowa's 99 counties to offer instruction to improve parenting skills regarding discipline, guidance, child development, and nurturing. In some communities, education projects added *Nurturing Healthy Sexual Development* to these programs. The aim of this expanded program is to help parents talk to their children about sexual abuse, take precautions to keep their children safe from sexual abuse, learn normal sexual development at different stages, and be willing to seek professional services when a real concern is identified. Because both programs are in place, the general parenting program (or "services as usual") made an ideal comparison to the sexual abuse oriented program. Similar parents are selected for both programs in that they have been determined to be in need of parenting instruction. This population, studied in a natural setting, could provide useful data in determining the feasibility and the benefits of offering this program as part of a general parent education program, as well as any barriers in program implementation and success.

As the only statewide organization focused on child abuse prevention, Prevent Child Abuse Iowa is often looked to for leadership in selection of good prevention approaches and programs. This will be particularly true regarding PCA Iowa's planned adult-focused sexual abuse prevention program. In committee debate and hearings, legislators have consistently noted the importance of increasing adult knowledge about how to protect children from sexual abuse. Legislators will be looking to PCA Iowa's program to achieve this goal – making the effectiveness of PCA Iowa's organizational efforts even more important than usual.

## **Methods**

### *Research questions*

1. How feasible is expansion of the existing programs to add sexual abuse prevention messages, with both individual and group instruction of the program? What are problems and strengths of this implementation?

2. To what extent do participants learn key concepts about child sexual abuse and child development, as compared with a wait-list control group?
3. To what extent are participants able to identify concerning behavior in children as compared to a wait list control group?
4. To what extent do participants indicate a willingness to take action around possible sexual abuse or its prevention, as compared with a wait-list control group?

There are two major aims of this evaluation. First, we aim to document the evaluation process and to discuss challenges, decisions, fidelity, and successes in the evaluation process. From this we draw on reports from site facilitators and PCA Iowa staff. We also utilize qualitative material provided in writing by participants, including participants and group or individual instructors for the program.

The second goal is to report findings regarding the knowledge gain and self-reported attitudes and readiness to act based on the training program. The data shows the degree to which the program impacted the knowledge of its participants and the program's overall strengths and challenges. This information will help PCA Iowa determine what, if any, changes it needs to make in the abuse prevention program to ensure its effectiveness. The evaluation report also serves as an invaluable future resource for PCA Iowa as it reviews and revises its adult-focused sexual abuse prevention instructional efforts.

### *Subjects*

Parents already enrolled in child abuse prevention programs provided by PCA Iowa-funded counties were selected for the study. A four-county site was chosen where parents were given in-home instruction on an individual basis. A seven-county site was selected where instruction was given in a group format. Two sites served as comparison groups and received only general parenting education. A total of 158 individual parents were involved in the study with 103 instructed in the new curriculum and 55 participating in the control group. Before participating in the study, perspective participants were provided with an informed consent document detailing their rights, the purpose of the study, and expectations for participants. (See Appendix 1). The ethnicity of participants was primarily white (82%) as is reflected in the overall Iowa population. Thirteen percent of the respondents were Hispanic.

### *Procedures*

The current study employed a quasi-experimental pre-test, post-test design. A control group was also used to increase the methodological rigor. Participants were recruited by workers in the field who were implementing the programs. There were few known refusals of participation, though it was made clear that participation in the study was not required to receive the services. Those signing informed consents completed a short survey instrument (See Appendix 2). The order of questions on the pre and post test was varied so that participants did not feel they were taking the identical survey before and after instruction. Some participants completed the post-test immediately after the one-time instruction, whereas others received multiple hours of instruction over multiple sessions before completing the post-test. A total of 200 participants were the original goal for the research study to see if the program is beneficial in the desired ways and in the desired settings and counties. Given program attendance, and the

desire to collect data in a timely manner, only 158 were part of the final study. All materials were kept confidential.

Participants were given the pre-test, which included demographic information that related to each parent. Information collected included participant's age, occupation, income and race. Additional questions asked about the number of children with disabilities in the home, age of children and current pregnancies. Participants were asked to check forms of stress with which they currently struggle, such as stress from work, transportation, health, childcare, and housing. They were also asked to check forms of assistance they were currently receiving, such as FIP, SSI, and food stamps.

Next, participants were given a list of statements and asked to rate their level of agreement using a 7-point Likert Scale. Questions were developed by examining the curriculum for key concepts and transferring them to the survey in statement form. Because there were three distinctive aims of the curriculum, three separate scales were devised to indicate where changes in scores occurred and where they did not. These scales were evaluated for reliability and both the identification of concerning child behaviors (Cronbachs=.905 for this sample) and willingness to take action (Cronbachs=.927) scales showed high reliability. The knowledge of facts scale only showed a reliability of .413; however, because it was a list of unrelated factual items, it served as an additive score of knowledge gained. (See Appendix 2 for sample survey).

Participants in the experimental group were then given the intervention of the *Nurturing Healthy Sexual Development* curriculum. The implementation of the curriculum varied somewhat from site to site, although efforts were made to standardize it to the greatest degree possible in a real-world setting. A protocol for program monitoring and details for evaluation procedures were developed and disseminated by the independent researcher. Implementation was monitored through PCA Iowa staff contact with each facilitator as well as phone conference calls including the project evaluator.

For the group-based sites, participants received the curriculum in a classroom-like setting. In-home sites were given the curriculum in a series of home visits. The time involved in instruction varied from under thirty minutes to two hours for individual instruction and from under thirty minutes to eight hours for group participants. The current study sought to explore not only the effectiveness of the curriculum but also the effectiveness in the way the curriculum was received. A post-test was then administered which contained all of the same questions but in a different order so as to avoid participant biases but to elicit the same information. This was useful in the final analysis because direct change could be measured. Participants in the control groups were administered both the pre- and post- tests but did not receive the intervention of receiving the curriculum instruction.

PCA Iowa staff worked with an independent researcher to guide the study plans and implementation. The research design, instruments, and procedures were conducted under an IRB at Louisiana State University, where the researcher works. In addition, PCA Iowa hired a master's level graduate student to assist in data entry and data analysis. PCA Iowa recruited evaluation sites based on their size and the estimated number of parents they could serve. Identified sites were sent a recruitment letter (See Appendix 3).

The child abuse prevention grants awarded to the sites were new the year this evaluation began. The selected sites included: a four-county home visiting site to measure the effectiveness of *Nurturing Healthy Sexual Development (NHSD)* in the home (Benton, Iowa, Linn, and Jones counties), and a seven-county group parent education site (Appanoose, Davis, Jefferson, Keokuk, Mahaska, Van Buren, and Wapello counties) to measure group-based effectiveness. The two

control sites (Louisa and Des Moines counties) were selected because they were also implementing group parent education in the same part of the state, thus reducing the potential differences between the group evaluation and control sites. There was not a home-based control site.

### *Measurement Tool*

In addition to demographic data which was collected, a survey was created explicitly for the program being evaluated. The design of the survey balanced the length of the survey against the perceived burden on respondents. In addition, reading level was kept at a lower level for the ease of respondents. The survey instrument had three scales: knowledge of facts, identification of concerning child behavior, and willingness/comfort with taking action. The instrument was designed with input from program facilitators, PCA Iowa staff, and the researcher consultant on phone conference calls.

Fact Scale: This researcher-designed 7 item survey was comprised of seven facts with respondents provided a 7 point Likert scale ranging from “strongly agree” to “strongly disagree”. This is considered an additive score since each fact can be learned independently. Scores could range from 7 to 49.

Concerning Child Behaviors: Because a program goal was to help identify and distinguish normal sexual development from serious concerning behaviors in children, a scale was created with 7 items to measure intervention benefits. Cronbach’s alpha for this scale was .905, demonstrating good reliability. Examples of statements, using the same 7 point Likert scale, include: “A young child touching or rubbing his/her own genitals” or “A child pressuring another child into sexual activity.” Scores could range from 7 to 49.

Willingness/Comfort with Taking Action: Another goal of the program is to encourage adults to take appropriate action when they have concerns about children or in order to prevent abuse from happening. This 10 item scale showed good reliability (Cronbach’s alpha=.927). Examples of statements rated on this Likert scale include: “I am willing to report child abuse” and “I would be willing to confront a family member if I was concerned that their behavior with a child was inappropriate.” Scores could range from 10 to 70. (See Appendix 2 for sample survey)

### *Data Analysis*

The research assistant entered pre and post quantitative data from each participant into an SPSS program. The evaluator then cleaned the data and computed the scales, reverse coding where necessary. Frequencies and descriptives were analyzed for each variable as well as for each scale. On scales, mean scores (using the scale mean) were utilized so that missing data did not necessitate omitting the participants with incomplete data. Reliabilities were computed for each scale. Both pre and post test mean scores were analyzed using ANOVA and independent T-tests to compare the three conditions. Means were compared for each group on pretest and on post-test measures first to determine if the groups started out with different levels of knowledge and awareness, as well as to establish a baseline for future comparison.

Pre and post test results for each individual were then evaluated, using paired samples T tests. In this way, even if groups were not equivalent in knowledge, gains could be ascertained on a case by case basis. Pre and post test scores were compared for each of the three scales and also for each item in the scale. In this way we could make conclusions about general areas of change as well as examine the specific areas in which change did, or did not, occur.

## **Results**

### *Feasibility*

Programs must have appeal to recipients and work for the program facilitators in order to successfully occur, or truly be feasible in any given community. Feasibility is a construct that explores if there is the capacity, willingness, open-ness, and skills to actually implement a program including consideration of the costs. Clearly the program was implemented in that 158 plus respondents were recruited. Although the goal was to reach 200 for the study, this outcome was considered successful given all the challenges in beginning a new program. Several problems were reported, but most had to do with recruitment and retention. Procedures for data collection appeared to be standardized and were well implemented. In general, recruitment for individual participants was easier in that the follow-through was more routine and location of the family was the site of the instruction. However, individually-administered programs are clearly more costly and take additional time, so that the value of a group-administered training was also of interest. However, with varying lengths of time of presentation of the material, both in the individualized and group context, and incomplete data on this variable, it is hard to decipher if any differences between individual and group programs were due to the amount of time (dosage) in training or the setting (alone or with others).

It was clear, however, from qualitative data provided, that participants perceived the program (both group and individual) positively and as personally beneficial. This is important, even though not a complete picture of program success, because eagerness to participate and perceived value is essential to involve and educate participants. A number of qualitative statements provided by participants provide some clue as to reactions to the program.

Participants shared appreciation for what was learned:

- “I learned about family members being the abuser and teaching my children about their body parts and that no one should touch them. . .”
- “I like this program because you can learn about child abuse and you can know the signs of child abuse.”
- “It was interesting. I learned how to talk to my children about this topic and how to be aware of this situation.”
- “I learned sometimes when children are being abused they think it is their fault.”
- “This program taught me a lot about sexual abuse that I didn’t know and being a mother, I am glad I know.”
- “This class was interesting. I wish it actually would have been a little longer of a program.”

Participants also offered information on the program trainers and their approaches:

- “I enjoyed the way it was done. I thought the powerpoint helped even more.”

“The presenter was awesome, very personable and relatable.”

“The presenter was very good at relating to us and making us feel comfortable.”

“I liked how they explained things to us.”

Suggestions for improving the program included:

“Invite more people for this kind of program placing ads, helping women who don’t know what to do or where to go for help (so they) can get the help.”

“Make more dynamic to make it less boring.”

“I think everything was well explained and presented.”

“Give out sheets with information on resources.”

“We all need this class!”

“I don’t personally agree with allowing children to masturbate or play with themselves. I was not taught that this is appropriate behavior.”

### *Pretest Findings*

Pretest findings were examined in several ways, including to compare groups for equivalency, to see pre-intervention levels of knowledge and responses, and to see if there was actually room for change (pretest scores were not so high---correct responses----that there was no opportunity for significant change to more accurate scores).

The groups were not found to be equivalent. In comparing the three conditions, there were significant differences on some demographic variables between the individually instructed, group instructed, and control groups. There were group differences on some markers of socioeconomic background: mother’s education, mother’s employment, and father’s education. In a closer examination of the data, it was found that the individual instruction condition had all white participants whereas the group instruction and control group were both comprised of almost 1/3 Hispanic participants. Those in the individual instruction group also were significantly more highly educated and were more likely to have both the mothers and the fathers participating. There was also a difference in reported stress levels between the groups. Further, regarding differences on scores on the survey items, there were two significant differences in responses to factual items. In “if children are not believed they will tell another,” there was a difference between the individual/home based group and the control group, with the individual condition participants more correct. On “An offender is more likely to attempt abusing a child if the child understands healthy sexual behavior,” the individually instructed again answered significantly more correct than the control group. On individual items in the scale for taking action, there were significant differences between groups (ANOVA) on willingness to confront family members, knowing when to report abuse, and knowing when to be concerned about a child’s behavior.

On the three scales, there were also some differences found between the three group conditions. The control group was significantly different from the group intervention (which had more correct answers) on the facts scale, but not on the two scales for willingness to take action, or identification of concerning behaviors in children. There was a significant difference between the individually administered (or home) condition and the control group on all scales, but on the taking action scale, the control group provided more correct responses than the home condition. Additionally, pretest scale scores showed no significant difference between the group and home

conditions on facts or willingness to take action, but there was a significant difference on identifying children's behavioral concerns, with the individual condition doing better.

What these findings suggest is that simply comparing overall results of groups will not be useful or meaningful since the groups were different in demographics and survey answers even before the intervention. Unfortunately, the individual conditions had overall higher scores, with the group condition having slightly lower scores, and the control condition having lowest scores before the programs.

### *Post Test Findings*

Not surprisingly, in comparing the three group conditions on post-test scale scores, the individual/home based group was still answering more correctly. Significant differences ( $p=.05$ ) were found between that condition and the two other conditions on both the fact scale and the concerning behaviors scale. There were also significant differences between the scores of the group instruction condition and the control condition on the facts scale, with the group instruction condition more correct in their responses. The group intervention condition also had improved scores over the control condition on both the concerning behaviors and willingness to take action scales, but these did not reach levels of significance. However, it should be noted that the group intervention found ALL behaviors as more concerning than did the comparison group, including those that represent normative child behavior (which was NOT the goal of the program).

Because the individual survey items were of particular use, in finding where the program was potentially affecting change in participants, each topic was also evaluated individually. This examination called into question the value of the scales since a gain in one question may have been minimized by a loss in another. In fact, this was found to be true such that the most valuable results are actually found in Table 1, where actual changes in response to each question are reported.

Comparing the control and the individual conditions, five of the eight survey items related to concerning child behaviors were significantly different post-test. The only ones which were not were two items that were NOT meant to be concerning and where both groups rated the behaviors as similarly disturbing. Unfortunately, the individual/home based condition rated the "finding pornography with an adolescent" as significantly more concerning, whereas at that age it is not considered an abnormal behavior.

As can be seen in Table 1, there were some significant individual item differences between the home and group conditions, although little regarding the facts. In the area of "Taking action," (Table 3) the group-administered participants felt they "know when to seek help" at a significantly greater level than those in the individual condition. Primarily, differences in items between the group and individual conditions were in the "Concerning Behavior" scale (Table 2). In all cases the individually-taught participants did better than the group-taught participants. Significant items included knowing that a child pressuring another to be sexual was concerning as was a young child having detailed sexual conversations with an older child and imitating intercourse. All non-significant differences were in the direction of individually-instructed subjects doing better than those who learned in a group.

In comparing individual post-test items between the group condition and the control condition, there were no differences on any of the concerning behavior items. However, on factual information, three facts were answered significantly differently and one more approached

significance ( $p=.058$ ). The significant items included that knowing about sexual matters does not make children at extra risk with offenders, that children frequently do not tell again if not believed, that false reports are not common, and that many children do not report abuse. The group condition, in regards to taking action, also were significantly more likely to feel more comfortable talking about child sexual abuse with children, and felt more likely to know when to seek professional help than those in the control condition.

Although there were no differences in willingness to take action between those in the individual and control conditions, there were five factual items where there were significant differences between the individual and control conditions post test. Additionally, there were significant differences on four items regarding concerning behaviors in children, with the individual condition means being more correct than the control condition on all items, both the significant and insignificant ones.

### *Changes in Individual Scores Pretest to Posttest*

Comparisons of pre and post scores by each participant were analyzed using paired samples T-tests. Scales were omitted because of the identified problems as noted previously. Individual items show that there was some significant learning in all three groups, particularly in regards to gaining factual information. In fact, mean scores were improved by one full number in five fact items for the group condition, one item for the individual condition and three items for the *control* condition. As can be seen from Table 1, the individual condition participants had more knowledge prior to the program than the group or control condition participants had after the study for three of the eight questions. On two of these questions the individual condition did not make significant gains (abuse can be without touch and knowledgeable children are at risk) but still knew more than either of the other two groups. Individually administered participants made significant learning gains in five of the factual questions, and both the group condition and control condition showed significant gains in five factual questions.

Perhaps more important than factual knowledge is the ability to identify concerning behaviors in children, in order to appropriately acquire services where needed, and the willingness to take action on behalf of children (see Table 2). None of the survey items in identification of concerning behaviors showed significant changes from pre to post test in the control condition. In the individual condition, only one (a child having age-inappropriate detailed sex talk with another child) showed significant changes post-program. In the group condition, all seven questions showed significant change, however three of these were in the wrong direction. All of these showed movement to being more highly concerned about normative childhood sexual behavior than before the program (i.e.: self-touch, exploration with a peer).

Table 3 shows mean change scores from pre to post on the respondents' willingness or ability to take action in light of concerns. In looking at pretest-posttest changes at a significance level of  $p=.05$ , the control condition significantly improved on one question about taking action, having to do with feeling comfortable with teaching children about healthy sexuality. The individual condition made significant gains in four areas of willingness to take action. The group administered condition had six significant gains (of 10) in the taking action questions.

### Conclusions and Recommendations

Although the groups were not the same prior to the interventions (or control condition), examination of gains in knowledge of each condition in the individual questions showed some

significant gains for both the individual and group conditions. While there were significant gains in more questions for the group condition, this might be attributed to the fact that the individual condition participants had less room to change since their answers were more desirable prior to the intervention. In fact, some mean scores post-test were significantly higher for the individual condition than for the group condition, even if the group condition had also made significant improvements over pretest scores. Because the individual condition started with higher scores, their post scores also were higher. They had less to learn. On the other hand, the group condition participants showed more significant gains in terms of numbers of questions than did the individual condition. To answer the question of whether the group condition is more or less effective than the individual condition, there will need to be equivalent groups for each condition in a future study.

Remarkably, the control condition showed significant changes, especially regarding the factual questions (See Table 1). However, on the few items where they made significant gains pretest to posttest, their responses often were still significantly less correct than those given by the individual or group condition participants, and often as different as a full point on a 7 point scale. It is possible that gains came solely from reflection on the questions or possible informal discussion with someone prior to taking the post-test. Based on information from program facilitators it is unlikely that there was any contamination by participants in the control group having contact with participants from either treatment condition. However gains were achieved (and most were in facts, which are easier to learn about than the other topics), it could be argued that curiosity or reflection which led to reconsideration just based on being asked the questions is not a bad outcome of the program.

Use of the scales provided some challenges since a closer examination showed that answers moving on the Likert scale in the wrong direction could skew results and produce a deceptive picture. For example, some participants (from all conditions) believed a young child exploring private parts with another child near in age was abnormal or concerning, whereas this may be normative. This item answered in the wrong direction could wipe out gains made on another question making the scale changes insignificant. Only when individual items were considered, did the true findings emerge, in some cases. Further, especially with the willingness to take action scale (and items) the issue of desirability responses arose. Very few people (from any condition) were willing to disclose hesitancy about reporting or challenging family members, or admit not knowing what was concerning enough to seek professional help. Because of this, a ceiling effect resulted whereby there was little room for improvement (since people were near perfect in their reported willingness to act---which actually flies in the face of research). Interestingly, the more educated the respondent, the less they evaluated their willingness to act as almost automatic and easy. If the answers are assumed to be honest, the willingness to report stays fairly stable for all conditions, staying between 1.1 and 1.3 for all groups regardless of pre or post test, indicating that all participants claim willingness to report abuse at near the extreme agreement (1 is strongly agree, 7 is strongly disagree). However, there were no significant gains made as a result of the interventions for any condition on this item.

Overall, the findings indicate significant movement from pre to post responses on all three topical goals: Fact items, Identification of concerning child behaviors, and Willingness to take action. All three conditions, including the control group, made significant gains on factual items, and it is possible that even the survey instrument may promote learning or seeking information that is unknown. However, it is clear that actual identification of concerning behaviors in children (and thus the ability to respond most helpfully) and the willingness to take

appropriate action requires more training and for these topics, the treatment conditions fared far better than the control condition. Nevertheless, items on these topics show a need for targeting some areas where there was little progress. One clear danger is that participants will become alerted to child sexual abuse and child behavior problems and become unduly alarmed by ALL sexual experimentation or exploration, even that which is developmentally normal. The problem with this may be the pathologizing of children and over-reactions which promote shame and punishment of curious children. Calming those parents with worries that are unwarranted may be just as important as helping parents with children who have serious problems find professional help. Regarding willingness to take action, this study would indicate that many adults may underestimate the difficulty of taking action, especially when the perpetrator is known and rate themselves unrealistically high in their ability. Training should also include how difficult these tasks may be in real life, as opposed to theoretically.

### *Strengths and Limitations*

This study has the limitations and the strengths of a quasi-experimental design. Because the study was undertaken in a naturalistic situation, random selection into conditions was not possible. Therefore, generalizing the findings to a larger audience is not possible. In addition, the attempt at creating comparable comparison groups was not successful regarding certain key demographic variables that indicate there was a class and ethnicity difference in groups, with the individualized instruction group more highly educated, more fully employed, and more likely to be white as compared with the two other groups. This limitation does raise questions about what it means that the individual instruction condition had better scores than either of the other two groups, both pre and post test. Perhaps we might conclude that individual instruction is superior, but it may be that other factors contributed to the score changes than simply the intervention condition. The survey was newly created and had a clear limitation in measuring willingness/comfort with taking action, with challenges due to participants likely over-rating their willingness or ability to take appropriate actions (especially the control condition). Few would argue that challenging a family member who may be sexually inappropriate with a child would not be difficult. No significant differences were found between groups after the intervention, but the scores were so high even at the pretest that a ceiling effect may have made significant change impossible to measure. In addition, the social desirability of reporting you would take action may not reflect true willingness to take action, as opposed to stating they would do so. Another limitation is that different leaders presented at each site and the quality of the instruction was not formally evaluated nor monitored for program fidelity. Because of this, it is uncertain whether or not some differences were due to the presenters.

Confusion about what was meant by concerning versus normative child sexual behavior may also have affected parental responses. While finding pornography in a teen's room is not necessarily desirable for a parent, it does not indicate necessarily that the child has a sexual behavior problem, nor does self-stimulation or youngsters doing peer exploration. However, exposure to the interventions, in some cases, made parents more concerned about some situations that should not be terribly alarming. Some parents may find that their child is frequently rubbing his genitals and think nothing of it because of his developmental stage. Another parent may notice this same behavior frequently as well and consider it in conjunction with other behaviors that are concerning. The latter parent may decide that there is a problem and seek professional help. The intention of this curriculum is to help parents better understand how to use their

judgment when it comes to these difficult situations. More attention to some of those issues is warranted.

It is interesting that the largest change, significant in all three conditions is from the “*All children are sexual*” statement. Another change for all groups was in the willingness to use appropriate technical terms for body parts, etc. with children. It is possible that in covering overall developmental issues in learning about children that these items were covered in some way in the control group. On the positive side, one of the control sites had parents express such interest in the material, that they underwent the NHSD training and became an evaluation site halfway through the study.

The NHSD programming was new to the areas at the time of this evaluation, which might be considered a limitation. The sites didn’t have time to establish the program in their communities before evaluation. The seven-county group-based site did not even apply for sexual abuse prevention funding from PCA Iowa the following year because they struggled to get parents involved in the program (as demonstrated in their low numbers). Furthermore, they experienced staff turnover halfway through the evaluation. These things may all have compromised fidelity to the program process and content, which was not monitored in this study.

Despite limitations, some challenges with recruitment, a lack of equivalency in the three conditions, and some instrumentation difficulties, this program shows significant gains for both individual and group condition participants on many of the individual questions targeted by program objectives. Attention should be paid to items where there were not significant gains; however, this program shows success in achieving its desired proximal aims. The relationship of these gains to actual reductions in child abuse, earlier interventions in concerning situations, and actual prevention of incidences remains to be explored.

**Table 1**  
*Comparisons of Fact Items*

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	Individual Pre/Post	Group Pre/Post	Control Pre/Post
Abuse without touch	2.07/1.78	4.58/3.35*	4.91/3.59*
False reports common	5.04/5.57*	4.30/5.85*	4.21/4.88*
Young touch for pleasure	2.79/2.11*	3.25/2.22*	2.83/2.21*
Children tell again if disbelieved	5.25/5.68*	5.16/5.41	4.31/4.68
Technical terms OK	2.34/1.38*	2.89/1.49*	2.88/1.87*
Knowledgeable child at risk	5.68/5.99	5.45/5.47	4.88/4.57
All children are sexual	4.86/2.46*	4.58/3.35*	4.91/3.59*
Half victims report abuse	4.68/4.76	4.47/4.41	3.86/3.60

**Table 2**  
*Comparisons of Identification of Concerning Child Behaviors*

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	Individual Pre/Post	Group Pre/Post	Control Pre/Post
Self-touch	4.46/4.33	4.63/3.96#	3.98/4.13
Detailed sex talk	2.27/1.75*	3.95/3.00*	3.48/3.06
Imitating intercourse	2.20/2.07	4.18/2.91*	3.44/3.11
Sexual teasing	2.52/2.38	4.02/2.98*	3.51/3.28
Porn in 12 yr. room	3.59/3.40	4.63/3.56#	3.98/4.00
Pressuring another	2.09/1.87	3.86/2.91*	3.36/3.24
Peer exploration	3.29/3.56	4.36/3.50#	3.90/3.84

**Table 3**  
*Comparisons of Ability/Willingness to Take Action*

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	Individual Pre/Post	Group Pre/Post	Control Pre/Post
Comfortable teaching	2.11/1.73	2.34/1.57*	2.64/2.07*
Equipped prevent	2.21/1.56*	2.34/1.43*	1.68/1.85
Discuss CSA with adults	2.23/1.95	2.66/2.06*	2.04/2.09
Understand how protect	2.79/1.71*	2.25/1.49*	2.04/1.78
Understand when concern	2.73/1.80*	2.39/1.55*	1.86/1.71
Willing to report	1.38/1.20	1.32/1.15	1.28/1.25
Know when to report	2.21/1.53*	1.91/1.53	1.50/1.62
Confront family inappropriate	1.91/1.64	1.82/1.53	1.51/1.65
Confront friend inappropriate	1.93/1.71	1.81/1.49	1.61/1.59
Know when seek professional	2.16/1.72	2.07/1.40*	1.77/1.82

\*Significant at the  $p=.05$  level

#Significant change in the wrong direction