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Author

Rudolph, Julia, Zimmer-Gembeck, Melanie J, Shanley, Dianne C, Walsh, Kerrryann, Hawkins, Russell

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Parental Discussion of Child Sexual Abuse: Is It Associated with the Parenting Practices of Involvement, Monitoring, and General Communication?

Julia Rudolph

Melanie J. Zimmer-Gembeck

Dianne C. Shanley

School of Applied Psychology and Menzies Health Institute of Queensland, Griffith University, Gold Coast, Australia

Kerryann Walsh

Faculty of Education, QLD University of Technology, Brisbane, Australia

Russell Hawkins

Psychology, College of Healthcare Sciences, James Cook University, Cairns, Australia

ABSTRACT

We investigated whether parents who reported more positive parenting practices (i.e., monitoring, involvement, and communication) reported more discussion of child sexual abuse (CSA) with their children. Parents from Australia and the UK (N = 248), with children aged 6 to 11 years, completed an online survey. About half of parents reported directly discussing CSA, whereas 35% reported telling their children that CSA perpetrators may be family members. Rates of discussion were higher for other CSA-related topics such as body integrity and abduction. Correlational analyses showed that parents who reported speaking to their children about CSA also reported more positive parenting practices, more discussion of other sensitive topics, and assessed CSA risk for children (in general) to be higher. Discussion of CSA risk was not associated with parents' CSA knowledge, confidence or appraisal of own-child risk. Parents higher in positive parenting believed their children to be at less CSA risk. Parents who appraised higher own-child risk reported less positive parenting practices and were less confident about their parenting and their ability to protect their children from CSA. The findings are the first to report on the associations of parenting practices with parents' CSA discussion with their children.

Parents are often encouraged to educate their children about the specific risks of sexual abuse (e.g., that someone may try to touch the child's genitals), the identity of possible perpetrators (e.g., family members and known adults), and what to do if the child feels at risk of abuse (American Academy of Pediatrics, 2015; Darkness to Light, n.d.). Given these efforts to encourage discussions, it is noteworthy that many parents report they do not discuss these prevention concepts with their children. For example, the proportions of parents who report that they warn their children (aged 3–12 years) about the possibility of someone touching the child's genitals has ranged from 23% to 64%, and those that tell

their children that their private parts should not be seen or touched by others has ranged from 41% to 66% (for a review, see Rudolph, Zimmer-Gembeck, Shanley, & Hawkins, 2017). Although the available research is somewhat dated, some parents in past studies have reported that children should not be directly taught that sexual abuse could happen to them or that known adults (particularly, family members) could be perpetrators of abuse (Elrod & Rubin, 1993; Wurtele, Kvaternick, & Franklin, 1992).

Child sexual abuse (CSA) prevention researchers have proposed several reasons for parents' reluctance to discuss CSA protection. These include: an inability or unwillingness to address topics of a sensitive nature, especially regarding sexuality (Davis et al., 2013; Reppucci, Jones, & Cook, 1994), insufficient knowledge (Tutty, 1993; Walsh, Brandon, & Chirio, 2012; Wurtele, 2008); a lack of confidence or low self-efficacy (Burgess & Wurtele, 1998; Walsh et al., 2012; Wurtele, 2008); or an assessment that children are at low risk (Collins, 1996; Elrod & Rubin, 1993; Reppucci, Jones, & Cook, 1994; Tutty, 1993). However, it may be the case that parents who do not discuss CSA risk and CSA protective behaviors with their children are using other protective strategies. In particular, associations between CSA discussion with children and positive and protective parenting behaviors, such as engaging in more monitoring of children's activities, being more involved in children's lives, and communicating more effectively (referred to here as *positive parenting practices*), have not been examined in previous research. Thus, there is a need for research that investigates whether parents' discussion of CSA risk with their children covaries with positive parenting practices. Such knowledge will progress practical CSA prevention work that relies on knowing how parents integrate general parenting practices with communication with their children about CSA (and other risks).

Parental protective behaviors and parents' discussion of CSA with children

Parental protection against CSA has almost always been measured in terms of parental capacity and willingness to discuss CSA risk and protective behaviors with their children (Briggs, 1988; Deblinger, Thakkar-Kolar, Berry, & Schroeder, 2010; Walsh et al., 2012; Wurtele et al., 1992). Although evaluation research has shown that children can learn CSA prevention concepts (Walsh, Zwi, Woolfenden, & Shlonsky, 2015), research to date has not been able to determine if an increase in children's CSA knowledge is able to protect them in an abusive scenario (Finkelhor, Asdigian, & Dziuba-Leatherman, 1995; Ko & Cosden, 2001; Pelcovitz, Adler, Kaplan, Packman, & Krieger, 1992; Finkelhor, Vanderminden, Turner, Shattuck, & Hamby, 2014). Similarly, links between parental discussion with their children of CSA risk and actual protection from CSA are yet to be explored. Measuring parental protection in this way rests on the assumption that parent-child discussion about prevention will protect children against CSA, or at

least aid children to report past or current abuse. Due to the large numbers of parents who report not discussing CSA with their children and the absence of an evidenced link between such discussions and protection, it is important to consider other ways that parents may be protective.

Two qualitative studies have considered parental protectiveness against CSA outside of a focus on discussion with children about risk and protection. In one study (Collins, 1996), a group of 24 U.S. parents, selected with maximum variation sampling methods, described a variety of strategies to keep their children safe from CSA. They talked of nurturing a close relationship with their children in order to allow comfort for disclosure, prevent children from falling under the influence of others, and build children's confidence. Parents believed supervision to be a critical protective factor, and almost all parents spoke about watching their children, with a number of parents describing at length the situations in which they supervise and monitor. Taking an interest in their child's life, routine questioning about their child's day, activities, concerns and feelings, and limiting of pastimes such as overnight stays were also seen as important. Parents also provided information, scrutinized and monitored child care options, checked for warning signs of abuse, and were cognizant of how protection might change as their children grew up, such as taking precautions with dating.

In the second study, 28 Australian parents, selected via nonrandom, purposive sampling, consistently referred to the significance of communication with their children (Babatsikos & Miles, 2015). Parents described the significance of open communication in building loving and supportive relationships, establishing trust, promoting monitoring of situations and problems, allowing the detection of negative incidents, aiding in the identification of solutions, and boundary-setting. Parents also attempted to decrease their child's risk of CSA by evaluating and monitoring social situations (such as sporting groups, playdates/sleepovers), gauging the comfort levels of children while in social settings and being wary of adults (especially males) who children seem to avoid or who are overly affectionate. These two studies demonstrate that parents are highly perceptive about the risks of CSA, contemplate their own children's situations and protection needs, and are resourceful in their application of protective strategies. Indeed, they reported using a variety of protective practices to keep their children safe, of which discussion of abuse prevention was only a small part.

Research on family and parental risk factors for CSA

Some of the behaviors described by parents as protective against CSA (Babatsikos & Miles, 2015; Collins, 1996) are consistent with the research that has identified a number of family-of-origin protective and risk factors for CSA. From this research, three overarching sets of factors (or *themes*) can

be extracted. The first theme is low supervision/monitoring of children by parents. This risk of children's CSA exposure when parents report low supervision has been documented in several studies (Davies & Jones, 2013; Finkelhor, Moore, Hamby, & Straus, 1997; Finkelhor, Ormrod, & Turner, 2007; Testa, Hoffman, & Livingston, 2011). In one study mothers who reported inadequate monitoring of their adolescent daughters' activities had children at an increased risk of sexual victimization (Testa et al., 2011). Another study found a significant predictor of a child being sexually abused was the child being left at home without suitable supervision (Finkelhor et al., 1997). Inadequate supervision and monitoring could also arise from other familial and parenting CSA risk factors such as parental absence (Herman, 1981; Leifer, Kilbane, & Kalick., 2004), parental physical or mental illness (Brown, Cohen, Johnson, & Salzinger, 1998; McCloskey & Bailey, 2000), parental alcohol and substance use (Leifer et al., 2004; McCloskey & Bailey, 2000), and child neglect (Laaksonen et al., 2011; Pérez-Fuentes et al., 2013). In addition, other domestic difficulties, such as marital conflict (Edwards & Alexander, 1992; Fergusson, Lynskey, & Horwood, 1996) and violence (McCloskey & Bailey, 2000; Ramirez, Pinzon-Rondon, & Botero, 2011), and social isolation (Finkelhor & Baron, 1986; Fleming, Mullen, & Bammer, 1997) could undermine a parents' capacity to provide appropriate levels of monitoring and supervision.

The second theme is the increased risk of CSA in family environments characterized by low involvement. Research has linked CSA risk with poorer parent-child relationship quality (Black, Heyman, & Smith Slep, 2001; Roberts, O'Connor, Dunn, & Golding, 2004); low parent-child attachment and bonding (Fergusson et al., 1996; Lewin & Bergin, 2001); neglect (Laaksonen et al., 2011; Pérez-Fuentes et al., 2013); emotional and physical abuse (Fergusson et al., 1996; Kim, Noll, Putnam, & Trickett, 2007); and parental mental ill-health (Brown et al., 1998; McCloskey & Bailey, 2000). In one longitudinal study (Butler, 2013), CSA risk was mitigated if the interviewer had rated the girls' primary caregiver as showing more warmth, love, and affection toward the child during interviews.

The third theme is the risk of CSA in families with poor parent-child communication. More frequent and positive communication may be protective against CSA, with one study reporting that effective maternal communication protected adolescent daughters from sexual victimization (Testa et al., 2011) and another reporting that households where "parents routinely ask questions and listen to their children [the children are] significantly less likely to become victims of sexual abuse" (Ramirez et al., 2011, p. 1029). Low quality parent-child communication may also be inferred from other findings such as the higher incidences of neglect, and emotional and physical abuse experienced by children with a history of CSA (Fergusson et al., 1996; Kim et al., 2007; Laaksonen et al., 2011; Pérez-Fuentes et al., 2013), and the

adverse circumstances present in the milieu of CSA-exposed children that may hinder effective parent-child communication such as parental absence, death, divorce, conflict, mental ill-health, or substance use (Fergusson et al., 1996; Leifer et al., 2004; Herman, 1981 ; Pérez-Fuentes et al., 2013).

The current study

Given that low levels of parental monitoring, involvement, and communication are known risk factors for CSA, it is surprising that no research has considered whether such general parenting practices are associated with parents' discussion of CSA risk and protective behaviors with their children. Thus, after describing rates of CSA discussion, the first aim of the present study was to examine whether parents who report more use of parenting behaviors that are considered positive for children (i.e., more monitoring, greater involvement, and more open communication) also report discussing CSA risks and protective behaviors with their children. The second aim was to understand whether parents' discussion of CSA is associated with certain "discussion facilitators" such as parents' greater willingness to discuss sensitive topics; greater parental knowledge of CSA; higher general parenting self-efficacy, and specific self-efficacy regarding CSA prevention; and an appraisal of children in general, and their child specifically, as being at risk of CSA.

Method

Participants and procedure

Participants were 248 parents (217 mothers and 23 fathers), aged from 20 to 59, living in Australia (81%) or the U.K. (19%). All parents were caregivers of a child between the ages of 6 and 11 years. The focal children were 108 boys and 132 girls, with a mean age of 8.6 years ($SD = 1.8$ years). Most participants were married or co-habiting (87%), with 10% divorced or separated. Regarding sociocultural background, 94% identified as white/Caucasian, 5% as Asian and 1% as Indigenous Australian. Tertiary education was reported by most participants: postgraduate (30%), undergraduate (29%), some university study (15%). Incomes were reported as under AUSS/£50,000 (15%), AUSS/£50,000 to AUSS/£100,000 (35%), AUSS/£100,000 to AUSS/£150,000 (30%), and over AUSS/£150,000 (20%) (denominations were the same for both currencies). Eight participants did not provide demographic information.

Participants reported on their own past experience with sexual abuse (with the term "sexual abuse" interpreted by the participant): 56 (23.3%) had a history of sexual abuse, 100 (42%) had knowledge of a partner or family member that had a history of sexual abuse, 80 (33.3%) had knowledge of a friend or acquaintance that had a history of sexual abuse, 34 (14.2%) currently

knew a child that had a history of sexual abuse, 67 (27.9%) knew someone who had been accused of sexual abuse, and 43 (17.03%) had worked in a professional capacity with sexual abuse victims or perpetrators. Seven participants (2.9%) reported that the focal child had experienced sexual abuse.

A series of independent group *t*-tests were conducted to identify differences in responses on all measures between the U.K. and Australia. There were some differences. Parents from Australia reported more discussion of CSA risk ($t(89.02) = 4.9, p < 0.01$), body integrity ($t(50) = 2.7, p < 0.05$), and abduction ($t(60.6) = 2.5, p < 0.05$). Parents from Australia also reported less positive parenting practices ($t(82.7) = 2.4, p < 0.05$) and parenting self-efficacy ($t(246) = 2.7, p < 0.05$), but higher general risk appraisal ($t(246) = 3.4, p < 0.05$).

Approval for the study was granted by the university Human Research Ethics Committee. Participants completed an online survey from July to November 2016. Forty primary schools in Australia and the U.K. agreed to post a recruitment flyer in the school newsletter or on the school's Facebook page. A recruitment flyer was posted on two parenting websites and in a parenting magazine (based in Australia). A recruitment e-mail was sent to staff and postgraduate students at an Australian university. Participants were asked to answer the survey about their child aged 6–11 years (or about one of their children of this age if they have more than one child within the range). Participants were eligible to be included in a draw to win one of three \$100AUD/£50 prize vouchers.

Measures

Parents' discussion with their children

Parents reported on the topics they had discussed with their children, indicating whether they had spoken about each topic and the degree of comfort they felt (1 denoted "Never," 2 denoted "Yes, but I felt uncomfortable with the discussion," and 3 denoted "Yes, and I felt at ease with the discussion"). Responses were averaged to create total scores, with a higher score indicating discussion with greater comfort. The following four areas of discussion were measured using this response format.

Parents' discussion about CSA risks with their children. Eleven items were used to determine whether parents had discussed CSA risks. Parents were asked questions which included specific abusive behaviors, protective behavior, and the identity of perpetrators (e.g., "that an adult/older person might touch him/her on their genitals/private parts," "that an adult/older person might show them 'rude' pictures"), Cronbach's $\alpha = 0.94$.

Parents' discussion about body integrity with their children. Parents answered two questions about discussion of body integrity with the focal

child (“*your body belongs to you*” and “*private parts are not ok to be seen or touched by others*”), Cronbach’s $\alpha = 0.76$.

Parents’ discussion about abduction safety with their children. Two items were used to determine whether parents had discussed abduction safety/ “stranger danger” with their child (e.g., “*Someone may temp, lure or grab you*” and “*what to do if someone attempts to temp, lure or grab you*”), Cronbach’s $\alpha = 0.87$.

Parents’ discussion about other sensitive topics with their children. Nine items were used to determine which sensitive topics parents had discussed with their children. Topics included online dangers, puberty, pornography, homosexuality, drugs/alcohol, sex, bullying, domestic violence, suicide and death, Cronbach’s $\alpha = 0.82$.

Parenting: Monitoring, involvement, and communication

Parental monitoring, involvement, and communication were measured with 45 items, including 28 items from established measures, and 17 items created for this study (guided by the literature on CSA risk factors). The created items were added to augment existing measures to gain a better understanding of monitoring, involvement, and communication as it relates to reducing children’s risk of CSA. No item specifically mentioned CSA or CSA risk reduction. Response options for all items ranged from 1 (“*never or almost never*”) to 5 (“*always or almost always*”). For each measure described below, items were averaged with higher scores indicated higher levels monitoring, involvement, or communication. Scores on the three scales were then averaged to create a total positive parenting score, Cronbach’s $\alpha = 0.87$.

Eighteen items measured parental monitoring, with six items drawn from the Parental Knowledge scale (Stattin & Kerr, 2000; e.g., “*I know who my child’s friends are*”), and five items drawn from the Parental Monitoring Instrument (Cottrell et al., 2007; e.g., “*I check on the specifics of planned activities*”). Cronbach’s α in the current study was 0.78 for these 11 items. Seven new items were developed to assess monitoring (e.g., “*My child spends time at home without adult supervision*”). Cronbach’s α for all 18 items was 0.79.

Twelve items measured involvement, including seven items adapted from the involvement subscale of the Alabama Parenting Questionnaire (Shelton, Frick, & Wootton, 1996; e.g., “*I play games or do other fun things with my child,*” Cronbach’s α in the current study for these 7 items was 0.66). Five new items were created (e.g., “*I am satisfied with the relationship I have with my child*”). Cronbach’s α for all 12 items was 0.75.

Fifteen items measured parent-child communication, with 10 items from the Parent-Child Communication subscale of the Pittsburgh Youth Study (Loeber, Farrington, Stouthamer-Loeber, & Van Kammen, 1998; e.g., “*I am satisfied with how my child talks to me,*” Cronbach’s α in the current study was 0.74 for these 10

items). In addition, five new items were created for this study (e.g., “*I have some quiet time to talk to my child every day*”). Cronbach’s α for all 15 items was 0.80.

Parents’ CSA knowledge

Parents’ knowledge of CSA was measured with an adapted and abbreviated version of the Parental Knowledge Questionnaire (PKQ; Tutty, 1993). Parents completed seven of the nine PKQ items reflecting CSA facts that are commonly misunderstood or underestimated, regarding perpetrators, victims and the nature of abuse, presented in a multiple-choice format, such as “*If a child has been sexually abused there will be physical evidence in cases.*” a. “*almost all*”, b. “*About half*,” c. “*Hardly any*” d. “*no.*” Possible answers include one correct option (given a score of 1), so that total scores range from 0 to 7.

Parental self-efficacy

Ten items from the Parenting Sense of Competence Scale (PSOC; Johnson & Mash, 1989; e.g., “*Being a parent makes me tense and anxious*”) were used to assess parental self-efficacy. Response options ranged from 1 (“*strongly disagree*”) to 6 (“*strongly agree*”); items were summed, with higher scores indicating parents’ greater sense of competence. The Cronbach’s α was 0.80.

Parents’ self-efficacy specific to CSA protection

To assess self-efficacy regarding CSA protective behaviors specifically, seven items of the PSOC were modified to be specific to CSA-related protective behaviors (e.g., “*I feel good about my ability to protect my children from sexual abuse,*” “*I believe I have all the skills necessary to protect my children from sexual abuse*”). Items were summed so that higher scores indicated more CSA protection efficacy, Cronbach’s $\alpha = 0.86$.

Parental risk appraisals

Parents indicated their perceived level of risk of CSA for children in general with the question: “*I believe all children are at risk of sexual abuse*” and the risk for their own child with the question: “*My child is less likely than other children to be sexually abused.*” This item was reverse scored. Response options ranged from 1 (“*strongly disagree*”) to 6 (“*strongly agree*”), with a higher score indicating greater perceived risk.

Results

Overview of data analyses

We first describe percentages of parents who discussed CSA risk, body integrity, and abduction dangers with their children. Correlations were then used to test whether parents who reported more monitoring, greater

involvement, and more open communication also reported more frequently discussing CSA risks and protective behaviors with their children. Similarly, correlations were conducted to test whether parents' discussion of CSA with their children was associated with parents' greater willingness to discuss sensitive topics; greater parental knowledge of CSA; higher general parenting self-efficacy, and specific self-efficacy regarding CSA prevention; and an appraisal of children in general, and their child specifically, as being at risk of CSA. Next, in order to determine if CSA risk discussion was associated with CSA experiences and demographic characterizes, further correlations were performed. Finally, regression analyses were used to examine whether parents' discussion with their children was uniquely associated with positive parenting practices and general risk appraisal, after considering child age and parental history of CSA.

Parents' discussion of CSA and prevention topics with their children

As shown in Table 1, just less than one-half of parents (44.8%) reported that they had spoken to their children about the risks of sexual abuse and felt comfortable doing so. Almost the same percentage of parents reported that they had not discussed CSA with their children (44.4%). The remaining parents (10.9%) reported that, although they had discussed CSA with their children, they had felt uncomfortable with this. When more specific queries

Table 1. Proportion of parents reporting discussion of CSA risk, body integrity, and abduction with their children ($N = 248$).

Topic	Proportion of participants, %		
	Never	Yes, but uncomfortable	Yes, and comfortable
Sexual abuse	44.4	10.9	44.8
Adult/older person might touch child on genitals/private parts	48.4	10.5	41.1
What to do if this happens	41.9	7.3	50.8
Adult/older person may get child to touch someone else's private parts	57.7	5.6	36.7
What to do if this happens	54.8	4.4	40.7
Adult/older person might show them "rude" pictures	71.4	2.0	26.6
What to do if this happens	69.0	3.2	27.8
Adult/older person may talk to child in a sexual way or about sexual topics	70.2	3.6	25.8
What to do if this happens	70.6	4.0	25.4
Adult/older person might try to temp, grab or lure child away	16.5	6.5	77.0
What to do if this happens	14.1	4.8	81.0
Never go with anyone unless arranged by a parent	1.2	1.6	97.2
Child's private parts are not ok to be seen or touched by others	6.0	2.4	91.5
Body ownership – child's body belongs to child	9.7	1.6	88.7
Perpetrator may be known to the child	60.5	6.0	33.5
Perpetrator may be a family member	64.9	5.6	29.4

were made, 51.6% of parents reported that they had told their children that an adult/older person may try to touch their genitals/private parts, with 41.1% of parents feeling comfortable and 10.5% feeling uncomfortable telling their child this.

An overwhelming majority of parents reported warning their child to never go with anyone unless it has been arranged by a parent (98.8%). Most also told children that private parts are not ok to be seen or touched by others (93.9%) and discussed body ownership (90.3%). Regarding perpetrators, a minority of parents (39.5%) told their child that a potential perpetrator could be someone known to the child, with 6.0% feeling uncomfortable doing so. Likewise, 35% of parents warned their child about the possibility of family members being perpetrators, with 5.6% feeling uncomfortable and 29.4% feeling comfortable giving their children this information.

Descriptive statistics

Table 2 summarizes the means and SDs (and the possible range of scores) for all variables. Parents reported relatively high scores on the positive parenting ($M = 4.2$, $SD = 0.4$), parental self-efficacy ($M = 48.1$, $SD = 7$), and appraisal of general CSA risk ($M = 4.8$, $SD = 1.2$) measures, with an average amount of CSA knowledge ($M = 4.3$, $SD = 1.4$) and appraisal of own-child risk ($M = 3.2$, $SD = 1.5$).

Associations between parents' CSA, body integrity, abduction discussion, and parenting practices

As shown in Table 2, positive parenting was significantly positively correlated with discussion of CSA risk, body integrity and sensitive topics, but not significantly associated with abduction. When specific parenting practices were examined, results showed that involvement was significantly positively correlated with discussion of CSA risk ($r = 0.26$, $p < 0.01$), body integrity ($r = 0.20$, $p < 0.01$), and sensitive topics ($r = 0.13$, $p < 0.05$). Monitoring was significantly positively correlated with discussions about body integrity ($r = 0.17$, $p < 0.01$), and communication was significantly positively correlated with discussion of CSA risk ($r = 0.16$, $p < 0.05$), body integrity ($r = 0.18$, $p < 0.01$), and sensitive topics ($r = 0.23$, $p < 0.01$).

Associations between parents' CSA, body integrity and abduction discussion, and possible discussion facilitators

Parents who reported higher rates of discussion of sensitive topics also reported higher rates of discussion of CSA risk, body integrity, and abduction (Table 2). Parents' CSA knowledge was not significantly correlated with

Table 2. Means, SDs, and correlations between all measures ($N = 248$).

	1	2	3	4	5	6	7	8	9	10
1. Discussion CSA risk	–									
2. Discussion body integrity	0.32**	–								
3. Discussion abduction	0.41**	0.30**	–							
4. Sensitive topics dis	0.43**	0.24**	0.29**	–						
5. Positive parenting	0.21**	0.20**	0.09	0.18**	–					
6. Parent self-efficacy	0.06	0.03	0.08	0.07	0.49**	–				
7. CSA self-efficacy	0.12	0.08	0.00	0.08	0.36**	0.56**	–			
8. CSA knowledge	–0.11	0.00	–0.22**	0.03	0.03	0.06	0.07	–		
9. Risk general	0.23**	0.28**	0.26**	0.12	–0.05	–0.06	–0.11	–0.05	–	
10. Risk CSA specific	0.07	0.07	0.06	0.03	–0.17**	–0.29**	–0.36**	–0.07	0.25**	–
Possible range of scores	1–3	1–3	1–3	1–3	1–5	10–60	7–42	0–7	1–6	1–6
Mean	1.7	2.8	2.6	2.2	4.2	48.1	31.7	4.3	4.8	3.2
SD	0.8	0.5	0.7	0.6	0.4	7.0	6.5	1.4	1.2	1.5

** $p < 0.01$.

Note. CSA = child sexual abuse. dis = discussion

communication about CSA risk or body integrity, but was significantly negatively correlated with discussion about abduction. This suggests that parents who were more aware of CSA facts and risk factors were less likely to warn to their children about the dangers of abduction.

Neither general parental self-efficacy nor efficacy regarding CSA protection, were significantly correlated with any of the areas of discussion (Table 2). Parental appraisal of the risk of CSA for children in general (i.e., “all” children) was associated with more endorsement of discussion of CSA risk, body integrity, and abduction. However, parents’ appraisal of their own child’s risk specifically, was not significantly correlated with any of the topics of discussion. It was noteworthy that specific (own child) risk appraisal was significantly negatively correlated with positive parenting and both general and CSA-specific self-efficacy. When parenting practices were considered independently, both parents’ monitoring ($r = -0.18, p < 0.01$), and communication ($r = -0.19, p < 0.01$) were associated with a lower level of specific risk appraisal.

Associations of CSA risk discussion with abuse history and demographics

Parents with a personal history of sexual abuse reported more CSA risk discussion with their children ($r = 0.21, p < 0.01$), as did those that knew an abuser ($r = 0.15, p < 0.05$) or a child that had been abused ($r = 0.24, p < 0.01$). Discussion of abduction dangers was positively associated with the parents’ personal history of abuse ($r = 0.21, p < 0.01$) or a family member history ($r = 0.14, p < 0.05$), knowing an abuser ($r = 0.17, p < 0.01$) or a sexually abused child ($r = 0.13, p < 0.05$). The only abuse-history measure associated with increased discussion of body integrity was working with victims of sexual abuse ($r = 0.16, p < 0.05$). Child age was positively correlated with CSA risk discussion ($r = 0.18, p < 0.01$) and abductions warnings ($r = 0.13, p < 0.05$), but not with discussion of body integrity. Child’s sex, and parent age, education, and income were not associated with any discussion measure.

Unique correlates of parents’ CSA discussion with their children

To examine whether parents’ discussion with their children was uniquely associated with positive parenting and general risk appraisal after considering child age and parental history of CSA, hierarchical regression analyses were performed. In each model, a measure of parental discussion was the dependent variable, and child age and parental CSA history were entered as independent variables at step one, positive parenting was entered at step two, and general risk appraisal was entered at step three. Regression

diagnostics did not identify any outliers, and there was no concern about multicollinearity in any model.

Parents' CSA risk discussion with their children

In Step 1 of the model of CSA risk discussion, child age and parents' personal history of CSA accounted for a significant amount of the variance, $F(2,237) = 8.78, p < 0.01, R^2 = 0.07$ (Table 3). In Step 2, positive parenting explained an additional 6.2% of the variance in CSA risk discussion, $F(3,236) = 11.90, p < 0.01, R^2 = 0.13$. In Step 3, general risk appraisal accounted for an additional 5.5% of the variance ($F(4,235) = 13.44, p < 0.01, R^2 = 0.19$). After Step 3 of the model, each of the independent variables was significantly positively associated with CSA risk discussion and accounted for 38.6% of the variance.

Parents' discussion of body integrity with their children

In Step 1 of the model of discussion of body integrity, age and parents' history of CSA did not account for significant variance (Table 3). In Step 2, positive parenting explained 6.0% of the variance in discussion of body integrity, $F(3,236) = 5.00, p < 0.01, R^2 = 0.06$. At Step 3, general risk appraisal accounted for an additional 9.8% of the variance, $F(4,235) = 10.99, p < 0.00, R^2 = 0.16$. After Step 3 of the model, 21.8% of the variance in discussion of body integrity was accounted for and both positive parenting and parents' general risk appraisal were significantly positively associated with parents' amount of discussion of body integrity with their children.

Table 3. Results of regression of parents' discussion with their children on child age, parents' CSA history, positive parenting, and parents' general appraisal of CSA risk ($N = 248$).

Predictor	Model 1		Model 2	
	Discussion of CSA risk		Discussion of body integrity	
	<i>B</i> (<i>SE</i>)	β	<i>B</i> (<i>SE</i>)	β
Step 1				
Child age	0.07 (.03)	0.16**	-0.00 (0.02)	-0.01
Parent CSA history	0.37 (.11)	0.21**	0.05 (0.07)	0.04
Step 2				
Child age	0.08 (.03)	0.18**	0.00 (0.02)	0.02
Parent CSA history	0.40 (0.11)	0.23**	0.06 (0.07)	0.06
Positive parenting	0.50 (0.12)	0.25**	0.30 (0.08)	0.24**
Step 3				
Child age	0.08 (0.03)	0.19**	0.01 (0.02)	0.03
Parent CSA history	0.35 (.11)	0.19**	0.02 (0.07)	0.02
Positive parenting	0.52 (0.12)	0.26**	0.31 (0.07)	0.26**
General risk appraisal	0.15 (0.04)	0.24**	0.12 (0.02)	0.32**

** $p < 0.01$.

Note. CSA = child sexual abuse.

Model 1 $F(4,235) = 13.44$, Final $R^2 = 0.19, p < 0.01$.

Model 2 $F(4,235) = 10.99$, Final $R^2 = 0.16, p < 0.01$.

Discussion

Parental discussion of CSA with their children is often encouraged as part of positive parenting practices believed to reduce children's risk of abuse. However, no previous study had examined whether parents who talk to their children about CSA, both in general and about the specifics of CSA risk and protection, are indeed the parents who also engage in more positive general parenting practices. Thus, our aim was to investigate whether positive parenting practices were associated with parental discussion about CSA risk and protective behaviors with their children. It was found that parents who reported more positive parenting practices, including more monitoring of their children's whereabouts and behaviors, more involvement, and more general communication with their children, were more likely to discuss CSA and body integrity with their children.

These results suggest that parents who reported more positive parenting practices are more aware of the prevention messages delivered by major CSA campaigns, and have incorporated them into their parenting, despite not reporting a greater amount of knowledge, or perceived risk of, sexual abuse. Interestingly, although results showed greater own-child specific risk appraisal was not associated with parents' greater CSA or body integrity discussion with their children, parents higher in positive parenting practices believed their children to be less at risk of CSA than other children. This suggests that parents who reported they were involved, monitored appropriately, and communicated effectively may feel more protective and believed this reduced their children's risk of sexual abuse. This was reinforced by these parents also reporting higher CSA specific self-efficacy. Related to this, when the parenting practices (monitoring, involvement, and communication) were considered in isolation, greater monitoring was not associated with discussion of CSA. Further research is needed to clarify the factors that impact on parents' use of either monitoring, CSA discussion, or a combination of both.

In this study, discussion of abduction dangers was not associated with positive parenting, or any of the individual parenting practices. This is perhaps because most parents report feeling comfortable discussing the danger of "strangers" with their children. Abduction has historically been the main concern of parents and the one they are most willing to talk about (Briggs, 1988; Finkelhor, 1984; Wurtele et al., 1992).

Parents' discussion of CSA risks with their children

We reported rates of discussion of CSA with children. Just over one-half of parents reported discussing sexual abuse risk and protective behaviors with their children, with a small proportion (about 10%) of these parents feeling

uncomfortable doing so. This is a substantial rise from early studies (e.g., Finkelhor, 1984) that found 23% of parents had discussed CSA risks with their children, but falls short of more recent results from the U.S.A. (79%: Deblinger et al., 2010) and Australia (66%: Walsh et al., 2012). When specific CSA behaviors and perpetrators were considered, just over one-half of parents (52%) told their children that an adult or older person might touch their genitals, and a minority of parents told their child that someone known to them (40%) or a family member (35%) might be responsible.

Parents in our study who discussed sexual abuse with their children were also likely to discuss body integrity and abduction. Regarding body integrity, we found that almost all parents reported they told their children that their body belongs to them (90%) and that their private parts should not be touched by others (94%). Studies specifically measuring this aspect of CSA are limited, but Walsh et al. (2012) reported that 40% of parents told their children that it is the child's right to decide who touches their private parts, and 74% of parents surveyed by Wurtele and colleagues (1992) thought that children should be taught this. These results demonstrate that, although almost one-half of parents reported they had *not* talked to their children about being the target of abuse and what that entails, almost all were willing to give their children more general information about private parts. This reinforces parent reports from studies conducted over two decades ago that found parents were unwilling to teach their children these concepts (Elrod & Rubin, 1993; Wurtele et al., 1992). More research is needed to clarify whether this more general approach to educating children about their bodies is as helpful as the more specific messages (that someone may try to touch their genitals and that the perpetrator may be known or a family member) recommended by CSA prevention initiatives and whether it may cause less child worry and mistrust.

Almost all parents (99%) told their children never to go with anyone unless it had been arranged by a parent, and a large majority of parents also warned their children that someone might try to lure or tempt them away (84%) and what to do if this happens (86%). These results are similar to those reported by Deblinger and colleagues (2010) but substantially higher than those documented by Walsh et al. (2012) who reported that only 39% of parents told their child not to go with a stranger and 31% told their child about what to do if someone tries to tempt them with rewards. Historically, parents have reported a willingness to discuss this type of risk with their children (Deblinger et al., 2010; Finkelhor, 1984).

Other correlates of parents' discussion of CSA risk with their children

Analyses of other explanations for CSA discussion rates, including discussion of other sensitive topics, CSA knowledge, self-efficacy, and risk appraisal,

revealed that only discussion of sensitive topics and perceived risk to children in general were related to parent-child communication about CSA, body integrity, and abduction. Researchers have suggested that parents who feel uncomfortable about sensitive topics in general will be less willing to discuss CSA with their children (Davis et al., 2013; Reppucci et al., 1994). However, the possibility of such an association has not been tested since Finkelhor (1984) reported that parents were more comfortable talking about a range of other sensitive topics (death, kidnapping, pregnancy and birth, drugs, mental illness, homosexuality, sexual intercourse, suicide, and abortion) than they were about discussing sexual abuse. The results of this study provide evidence of an association between comfort levels discussing sensitive topics (e.g., puberty, pornography, homosexuality, drugs/alcohol, sex, bullying, domestic violence, suicide, and death) and CSA, with those parents who had discussed more sensitive topics with their children also discussing CSA, body integrity, and abduction to a greater extent. Parents who scored higher on the positive parenting measure were also more likely to discuss sensitive topics.

Although not previously empirically investigated, it has been suggested that if parents were more knowledgeable about CSA and its risks, they would be more likely to discuss dangers with their children (Deblinger et al., 2010; Walsh et al., 2012). However, we found that parental knowledge of CSA was not significantly associated with communication about CSA or body integrity. Interestingly, parents with greater knowledge of CSA facts were *less* likely to warn their children about the dangers of abduction. This may indicate that parents who are more knowledgeable about CSA risks are aware that children are at much less risk of abduction by strangers, than grooming and sexual abuse by someone known to them, and may not prioritize this for discussion with their children.

Theories of psychological health behavior change such as the Health Belief Model (Janz, Marshall, & Becker, 1984) and Protection Motivation Theory (PMT: Rogers, 1975) include risk appraisal and self-efficacy as prerequisites to positive behavior modification. For example, in PMT, when confronted with a health threat, an individual appraises the harmfulness of the threat, the likelihood of occurrence of the event, and the efficacy of a recommended coping action in averting the threat (response efficacy), and has a belief that they are capable of successfully performing the functional response (self-efficacy). We found no significant association between parents' CSA discussion with their children and parenting self-efficacy or CSA-specific self-efficacy. This may suggest that parents did not view the discussion of CSA with their children as the only, or even the most important, protection strategy. However, the present results showed self-efficacy, of both types, was related to less perceived own-child risk, suggesting that parents who were confident in their parenting and CSA protection capacities believed that they

may be reducing the risk of CSA for their own children and reducing the need for discussion of specific CSA risks with them.

In support of the PMT model, parents in the current study who felt that children in general were at greater risk of sexual abuse were more likely to talk to their children about CSA, body integrity, and abduction. However, parents' higher appraisal of their own child's risk specifically was not associated with discussion about any of the three areas of risk. Interestingly, parents with higher own-child risk appraisal used less positive parenting practices and were less confident about their parenting and ability to protect their child from CSA. When the positive parenting practices (monitoring, involvement, and communication) were considered, parents who perceived their child to be at less risk than other children, monitored more and engaged in better communication with their children.

Self-efficacy and risk appraisal have not been studied in relation to CSA prevention behavior per se; however, Campis, Prentice-Dunn, and Lyman (1989) found both response efficacy and self-efficacy promoted attitude change regarding intentions to discuss CSA. Likewise, Burgess and Wurtele (1998) assessed parents' threat appraisals (i.e., their beliefs about the severity of CSA and their children's vulnerability) and their coping appraisals (i.e., self-and-response efficacy) after attending a CSA-prevention workshop and found self-efficacy and response efficacy were both significant predictors of parents' intentions to discuss CSA with their children.

Demographic characteristics and parents' discussion of CSA risk with their children

Research on the association between demographic characteristics and parents' discussion of CSA has yielded inconsistent results (Babatsikos, 2010; Deblinger et al., 2010; Finkelhor, 1984; Walsh et al., 2012). Adding to the mix of findings, we found no association between child's sex, and parent age, education, and income with discussion of CSA risk, body integrity, or abduction. However, child's age and a participant's history of CSA, either directly or through knowing an abuser or a victim of abuse, was associated with increased discussion of CSA and abduction. These factors were not associated with parents' discussion of body integrity, which was only associated with participants' history of working with victims of abuse.

A comment on sample's CSA histories

The numbers of participants who reported experiences with CSA are noteworthy. Although only 2.9% of participants reported that their child had been abused, almost a quarter of participant reported that they themselves had been sexually abused. These reports came mostly from women, with only

1 of the 23 male respondents reporting a history of personal abuse (4.3%). In addition, almost one-half of the sample reported knowing a family member that had been sexually abused and one-third of participants knew a friend or acquaintance that had been sexually abused. That 27% of respondents knew someone who had been accused of sexual abuse is to be expected as a high percentage of sexual abuse occurs within family and friendship networks; therefore, knowing the victim increases the likelihood of knowing the offender. Rates of CSA incidence vary from 4% to 26% for women and 1.4% to 12% for men (Australian Institute of Family Studies, 2017; Finkelhor, Shattuck, Turner, & Hamby, 2014; National Centre for Victims of Crime, 2012). This study provides further evidence of the prevalence of CSA in Australia and the U.K.

Study limitations and future directions

Some limitations of the current research study must be noted. The sample consisted of predominately Caucasian well-educated mothers living in Australia and the U.K. who responded to invitations to participate, which might limit the generalizability of the results. Although the percentage of participants identifying as Asian in this sample is roughly representative of the Australian and U.K. populations, the percentage of Indigenous Australians was 2% lower than the Australian population. The number of participants who had postgraduate qualifications exceeded that of the Australian and U.K. populations and the incomes were also higher than that of the populations in general. This could be a result of conducting some advertising for participants through a university. This may also be the explanation for the high number of participants who reported working with victim and/or offenders. In addition, the problem of self-reporting of parenting practices suffers from the usual biases (i.e., reporting in a socially desirable manner, errors in recall of events). Future studies could consider using observations of parenting practices and multiple informants or supplementing with child report of parents' discussion of CSA risk. Finally, the number of participants who reported that they had a child who had experienced sexual abuse (2.9%) was lower than might be expected in the general population (<https://aifs.gov.au/cfca/publications/prevalence-child-abuse-and-neglect>, <https://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/child-sexual-abuse/sexual-abuse-facts-statistics/>), possibly due to socially desirable reporting or parents being unaware of their child's abuse at the time of the survey. This low rate precluded the analysis of associations between child's personal experiences with CSA and the areas of interest considered in this study.

Some statistically significant differences in responses between Australia and the U.K. were identified. Compared to U.K. participants, Australian participants reported more concern about CSA in general and spoke to their children more about CSA and related topics. However, they reported

less use of positive parenting practices and lower parenting self-efficacy. Due to the low number of U.K. participants (46) in this study, further research must be conducted to fully understand these differences.

Conclusion

The major benefits of the current study lie in the novel investigation of: a) the association between aspects of positive parenting (that might be protective against CSA) and parental discussion of CSA (and related topics), and b) past suggestions as to why parents are reluctant to have these discussions with their children. The findings showed that parents who report more positive parenting practices also engage in more direct communication with their children about CSA, feel that their children are less at risk, and report more confidence about their ability to protect their children from sexual abuse. This suggests that one indirect effect of programs that focus on increasing parents' positive interactions with their children may be enhancing their CSA protective behaviors. Important to note is that, although almost one-half of parents reported not communicating specific CSA information to their children, almost all parents gave their children more general messages about private parts and body integrity. As research over the last 30 years has demonstrated, increasing parental willingness to talk about the specifics of abuse and perpetrator identities may not be realistic.

Given the focus on parental education of their children as important for the prevention of CSA, efforts should also be dedicated to understanding the reasons why a substantial proportion of parents do not discuss the specifics of CSA risk with their children. It is possible that some parents have understood prevention in behavioral terms, viewing their role as primarily one of safeguarding children through positive and involved parenting practices, rather than engaging in direct discussion of CSA risk. For other parents, direct child education about the risk of CSA may be seen as an adjunct to other protective parenting practices. Future research could build on our findings by more directly addressing these possibilities.

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