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WHEN AGE MATTERS: CHILD AGE AS A MODERATOR OF OUTCOME IN A CAREGIVER PREVENTION PROGRAM FOR ABUSE AND BULLYING

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ABSTRACT

WHEN AGE MATTERS: CHILD AGE AS A MODERATOR OF OUTCOME IN A CAREGIVER PREVENTION PROGRAM FOR ABUSE AND BULLYING

Jenni R. Marques

Childhood physical abuse (CPA), childhood sexual abuse (CSA), and bullying continue to impact children across the United States at an alarming rate, with immense psychological, physiological, and social cost (Child Maltreatment, 2020; U.S. Department of Justice, Bureau of Justice Statistics, 2017; Carr, Duff, & Craddock, 2018; Ferrara et al., 2019). While majority of prevention programs target elementary age children (6-10), there is some disagreement amongst researchers as to the appropriateness of introducing these programs to children of the pre-school age (3-5 years). Keeping Every Child Safe (Child Safe; Brown & Beekman, 2014) is an evidence-based primary prevention program for caregivers of children ages 4-8, found to increase caregiver knowledge and use of protective behaviors regarding CPA, CSA, and bullying prevention (Brown, Canter, Chaplin, & Beekman, 2017). Seventy-two caregivers with children ages 4-8 participated in an open trial of Child Safe and were assessed before and after attending the Child Safe for Parents workshop. This study investigated the role of child-age in caregivers' ability to learn preventative information and adopt protective behaviors. The results of the moderation analyses indicated that child age did not influence caregivers' growth in knowledge or use of protective behaviors, challenging the assumption that children must be of a certain age for caregivers to benefit from

prevention training. In doing so, this study provides important implications for public policy, prevention research, and school practices.

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To my best friend and my biggest fan, thank you mom. I am the daughter, sister, friend, and woman I am today because of you. Thank you for the daily phone calls, the self-care pushes, and the reminder that life is never that serious. This one's for you!

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Introduction

Childhood physical abuse (CPA), childhood sexual abuse (CSA), and bullying remain widespread public health concerns (Child Maltreatment, 2020; U.S. Department of Justice, Bureau of Justice Statistics, 2017). Existing programs designed to prevent CPA, CSA, and bullying are limited in efficacy due to high cost, burdensome time commitments, and the omission of parents, who play a key role in prevention efforts (Brown, Canter & Beekman, 2015, November). Keeping Every Child Safe (Child Safe; Brown & Beekman, 2014) is a primary prevention program aimed at educating caregivers of children ages 4-8-years old on strategies to protect their children from sexual abuse, physical abuse, and bullying. Aimed to address barriers identified in prevention programing, Child Safe consists of one workshop, Child Safe for Parents. Child Safe is provided in both English and Spanish, provides free childcare for caregivers during workshops, and offers comprehensive training across prevention topics (i.e., CSA, CPA, and bullying). Child Safe for Parents has been found effective at both increasing caregiver knowledge and increasing the use of protective behaviors regarding CPA, CSA, and bullying prevention (Brown, Canter, Chaplin, & Beekman, 2017).

While most abuse and bullying prevention programs target elementary school children (Finkelhor, 2009; Walsh et al., 2018; Brassard & Fiorvanti, 2015), there is some resistance to providing prevention training to caregivers of pre-school children. Preschool children may have limited cognitive capacity to understand nuanced concepts such as abuse and bullying (Renk et al., 2002; Tutty, 2000). Additionally, developmental differences between pre-school and early elementary children reflect differences in parent-child interactions. During the preschool years (3-5 years of age) children are

provided with regular supervision and close parental monitoring. Protective behaviors such as drop-off policies and monitoring of peer interactions may not be as applicable at this age. As children enter grade-school (6-8 years of age) they begin to develop independence. Children at this age begin to take the bus to school, enroll in extracurricular activities, and attend regular play-dates (Giallo et al., 2010; Ladd, 1990; Rice & O'Brien, 1990). With more independence, there is an increase in risk for both abuse and bullying (Finkelhor et al., 2015; Brassard & Fiorvanti, 2015), which is why majority of prevention programs are introduced during the late elementary school years. The importance of preparing and supporting caregivers during this transition is critical (Kraft-Sayre & Pianta, 2000; Margetts, 2000).

While grade-school children (6-10 years of age) remain primary targets of prevention programing, primary prevention suggests that targeting children earlier in life, prior to when they are at their most vulnerable, may be an important next step. Child Safe aims to provide evidence-based practices that extend below the 6-10 age range by targeting parent and child dyads as early as 4 years of age. The push to extend primary prevention programing earlier in a child's life has important implications for prevention practice and policy. This study explores the moderating role of child age on the effectiveness of the Child Safe of Parents workshop.

Need for Effective Prevention

Prevalence of Child Abuse and Bullying. Rates of abuse and bullying in the United States are alarming. In 2018 alone, 4.3 million child maltreatment referrals were reported, including over 460,000 CPA victims and over 300,000 CSA victims (Child Maltreatment, 2020). Bullying is the most commonly reported discipline problem across

public schools, with one out of every five (20%) of students reporting being a victim of bullying (U.S. Department of Justice, Bureau of Justice Statistics, 2017).

There is a surge in CPA, CSA, and bullying in the middle of elementary school. According to the Crimes Against Children Research Center, children are at the highest risk for CSA between the ages of 7-14 (Finkelhor, et al., 2015). Physical abuse is most common amongst children ages 6-9 (46%) (Finkelhor et al., 2015). Bullying prevention efforts have been targeted at the early elementary school ages to reach children before the peer victimization rates escalate (Brassard & Fiorvanti, 2015).

Psychological and Economic Costs of Child Abuse and Bullying. The psychological consequences of abuse and bullying can be severe. Children who experience sexual and/or physical abuse have higher rates of behavioral problems, mental health conditions, physiological health conditions, and an overall reduced quality of life (Carr, Duff, & Craddock, 2018). Similarly, children who are victims of bullying are also at a higher risk for negative physiological, psychological and social outcomes. (Ferrara, et al., 2019).

There is an economic burden of child abuse and bullying in the United States. According to the San Francisco Child Abuse Prevention Center, each incidence of child abuse costs the public $400,533 over the course of the victim's lifetime. The CDC estimates that the cost associated with child abuse in 2015 alone was approximately $428 billion (Peterson, Florence, & Klevens, 2015). Student absences due to bullying are costing school districts close to $2.3 million (Russell, 2017).

Prevention Programs of Abuse and Bullying

Primary prevention programs aim to prevent the occurrence of an adverse event before it ever occurs (Wallace, 2006). Successful primary prevention program increase participants' knowledge and use of protective behaviors (Durrant & Ensom, 2012). Although there are numerous primary prevention programs aimed at reducing abuse or bullying prevention, majority of programs are limited by scope, scientific rigor, and accessibility. Specifically, majority of programs focus on the prevention of just one type of adverse childhood experiences. Below is a brief review of prevention science addressing CSA, CPA, and bullying.

CSA Prevention. Successful CSA prevention programs include those that incorporate parental involvement, increase parental supervision, and educate children on body safety (Mendelson & Letourneau, 2015; Pulido et al., 2015). Appropriate verse inappropriate touch, anatomical names of private parts, and disclosure to a trusted adult are important concepts of prevention education for children (Kenny et al., 2008). Increasing a child's prevention knowledge and skills likely increases their awareness of potentially dangerous situations and decreases their compliance with possible offenders (Ko & Cosden, 2001). Teaching parents about these concepts may also increase the likelihood of a supportive response to a child's disclosure of sexual abuse (Hébert, Lavoie, Piché, & Poitras, 2001).

Walsh, Zwi, & Woolfenden (2018) conducted a meta-analysis of 24 CSA prevention programs. Criteria of the studies included: 1) targeted children 3-18 years, 2) delivered through school-based prevention programs, 3) were peer-reviewed. The outcome variables of the analysis included: change in knowledge about CSA prevention,

protective behaviors, retention of knowledge and behavior over time, child and parent anxiety, and frequency of disclosures during or after programs. Authors found that almost all of the programs were effective in increasing knowledge (SMD of 0.61, 95% CI = [0.45, 0.78]; 18 studies, n = 4,657) and preventive behavior (OR = 5.71, 95% CI = [1.98, 16.51]; two studies; n = 102). A limitation of this study includes methodological shortcomings such as inclusion of quasi-experimental designs, resulting in a lack of understanding regarding the true impact of some programs.

Successful CSA prevention programs are those that focus on both the acquisition of knowledge and behavioral skills (Wurtele 1987a). Rheingold et al. (2015) conducted a randomized control trial (RCT) of Stewards of Children (Stewards), designed to educate adults on ways to prevent, recognize, and react responsibly to CSA. A group of 352 childcare professionals were randomized to one of three conditions (1) Stewards in-person training, (2) Stewards web-based training, or (3) waitlist control. CSA knowledge, CSA attitudes, and self-reported CSA preventive behaviors were assessed at pre, post, and 3-month follow-up. Authors found that Stewards improved CSA knowledge, attitudes, and preventive behaviors. CSA knowledge and behavior improvements were seen immediately following the workshop and maintained at 3-month follow up, for both in-person and web-based trainings. A limitation of the study included post-only assessment for knowledge, resulting in lack of understanding about baseline equivalence and therefore, limiting the conclusiveness of gains in knowledge being attributed to the intervention itself.

Existing CSA prevention programs tend to focus solely on strategies directed towards children, despite the evidence supporting the need for parent training (Finkelhor,

2015; Rheingold et al., 2012; Wurtele et al., 2008). Guastaferro et al. (2023) conducted a longitudinal study of Safe Touches, designed to educate children on personal safety regarding private body parts and appropriate body contact. A sample of ~14,235 children in second grade received the Safe Touches workshop. Children's knowledge of abuse was assessed one week prior to the workshop, immediately after the workshop, 6 months and 12 months after the workshop. Authors found that children who attended Safe Touch showed significant improvement in knowledge gains and maintained those gains over time. Limitations of the study included: lack of parent involvement, lack of demographic information on participants, and lack of behavior measures, limiting the understanding of possible moderating factors (i.e., race/ethnicity, social-economic status) and the impact of programing on behavior change, which is an essential part of prevention training.

CPA Prevention. Parental involvement is a key component of abuse prevention training, as it has been found to improve and maintain protective skills (Gubbels, Van der Put, Claudia, Stams, & Assink, 2021; Kenny, et al. 2008; Topping & Barron, 2009). Successful CPA prevention programs are those that educate caregivers on negative consequences of corporal punishment, provide alternative discipline strategies for caregivers, and increase caregiver's sense of self-efficacy (Haskett, et al., 2006; Turner & Sanders, 2006). Van der Put et al. (2018) found larger effect sizes for abuse prevention programs that targeted parent self-confidence, specific parenting skills, and social-emotional support.

Chen & Chan (2016) conducted a systematic review and meta-analysis of CPA prevention parenting programs. A sample of 37 RCT trials published before September 2017 were evaluated based on three factors: reduction in child maltreatment, reduction in

parental risk factors, and the enhancement of parental protective factors. Results of the review suggest that majority of programs successfully reduced substantiated and self-reported child maltreatment reports (d = .208), reduced risk factors (d = .612), and enhanced protective factors (d = .342). A limitation of the study is the inclusion of primary, secondary, and tertiary programs, resulting in a lack of understanding of the efficacy of primary prevention programs alone (Chen & Chan, 2015).

Majority of CPA prevention programs are time consuming and require extensive parent involvement. Knox, Burkhart, & Howe (2011) conducted an open-trial of ACT-RSK, designed to educate caregivers on CPA prevention strategies. A sample of 87 parents of children (ages 1-10) attended eight 90 to 120-minute group sessions over eight weeks. Child behavior and caregiver behavior were assessed pre and post intervention. Authors found that ACT-RSK reduced the frequency of child conduct problems reported by participating caregivers. Limitations of the study included: failure to assess caregiver behavior change and acquisition of knowledge, limiting the understanding of the direct impact of the program on parents alone. Existing CPA programs may be effective, but existing literature often falls short of scientific rigor.

Bullying Prevention. Children's behavior patterns are highly influenced by family dynamics as they learn to observe and adopt strategies for conflict resolution, self-regulation, and interpersonal skills from their parents and other family members (Cross & Barnes, 2014; Georgiou & Stavrinides, 2013; Robers & Morotti, 2000). Parenting styles have been found to be associated with risk for childhood bullying, with children of authoritarian parents at higher risk for perpetrating bullying behavior and children of permissive parents at higher risk for victimization (Georgiou & Stravrinides, 2013).

Successful bullying prevention programs include caregiver education on risk factors for victimization, instruction on how to provide proper supervision of children and peer interactions, and instruction on modeling appropriate behavior **(**Grassetti et al., 2018; Rigby & Johnson, 2005).

Farrington & Ttofi (2009) conducted a cross-national meta-analysis evaluating 44 school-based anti-bullying programs. All studies included control-experimental group comparisons and the necessary data for calculating effect size. Program elements considered in effect size calculations include: parent trainings, adult supervision, intensity (children & teachers), duration (children & teachers), and other specific program components. Authors found that most school-based bullying prevention programs decreased bullying behavior by 20%-23% and victimization by bullies by 17%-20%, concluding a significant effect for anti-bullying programs (r = .12). Limitations of the study include failure to meet adopted threshold for practical significance ($r \geq .20$).

Successful bullying prevention programs are those that encompass a community-based approach, including caregiver involvement (Evans, Fraser, & Cotter, 2014; Ferguson, Miguel, & Kilburn, 2007; Ttofi & Farrington, 2009). Cross et al. (2018) conducted a group- RCT of Friendly Schools Friendly Families (FSFS) program, designed to educate students, teachers, and parents on bullying prevention strategies. A sample of 1,144 parents of students in grades 2, 4, and 6 participated in the program and completed pre and post assessments. Parents were assessed on their knowledge, self-efficacy, attitudes, perception, and behavior regarding bullying at baseline, 10 months, and 22 months post intervention. Authors found parents of students in grades 2 and 4 increased in self-efficacy and in the frequency of communication with their children

regarding bullying. Parents of students in grade 4 also reported an increase in positive attitudes towards victims of bullying, while parents of students in grade 6 did not show any changes at all. Limitations of the study include lack of knowledge measures, limiting the understanding as to whether parents retained information presented during the intervention.

Limitations of Existing Programs. The most effective prevention programs are those that both reduce the environmental risk of children, such as their exposure to potential abusers/bullies, as well as increase the parent's awareness of prevention topics, including both signs of abuse/bullying and ways to report abuse/victimization (Grassetti et al., 2018; Kenny & Wurtele 2012; Ttofi & Farrington, 2011; Rigby & Johnson, 2005; Wurtele & Kenny 2012). Despite evidence to support parental involvement, most existing programs, for both abuse and bullying prevention, do not incorporate parents or require extensive time commitments, limiting the program accessibility (Kenny, 2009; Rheingold et al., 2007). Barriers to caregiver engagement in prevention programs are: most programs are only available in English, families need child care, programs are long but only cover one topic (e.g., one form of abuse), programs ignore barriers to using skills, and are too costly. These barriers result in lack of enrollment, see higher rates of attrition, and more biased study samples (Coatsworth et al., 2006a; Dumas et al. 2007; Ingoldsby, 2010). In turn, studies suggest that longer, more demanding programs are not associated with higher program efficacy (Finkelhor & Dziuba-Leaterman, 1995). Additionally, despite Latino/a children being at a slightly higher risk for CSA than non-Latino/a children (Fontes & Plummer, 2010; Sedlak et al., 2010), the number of effective evidence-based prevention programs provided in Spanish is limited (Kenny, 2009a).

Addressing the Limitations: Keeping Every Child Safe

Keeping Every Child Safe (Child Safe; Brown & Beekman, 2015) was developed to address the limitations of existing programs and directly confront barriers to implementing evidence-based prevention strategies. Child Safe for Parents is a 2.5-hour prevention workshop, with modules covering CSA, CPA, and bullying, presented in a group of parents and other caregivers. In each module, caregivers learn about the prevalence of each issue (CSA, CPA, bullying) and evidence-based strategies shown to protect children. Caregivers also brainstorm possible barriers to implementing what they learned and solutions to overcoming these barriers.

Brown, Beekman, & Canter (2017) conducted a randomized controlled trial of Keeping Every Child Safe. A sample of 54 caregivers (Mean Age = 42; 76% female; 72% Caucasian) of children ages 4-8 were randomized to attend Child Safe for Parents with the first cohort (January) or the second cohort (March). CSA knowledge and protective behavior were assessed at five time points: pre (January), post –Child Safe, 2-weeks post-Child, and 6-week follow-up. Brown et al. found that caregivers who attended Child Safe for Parents showed significantly greater increases on knowledge and protective behavior at Times 2 and 3. Phase two was a comparison of the two groups after the original waitlist group received Child Safe for Parents. At times 4 and 5, the January group maintained their improvements and the March group showed significant increases in knowledge and protective behavior, such that there were no differences between groups at time 5. In an open-trial of Child Safe (Canter & Brown, 2017), increases in caregiver knowledge from Time 1 to Time 2 were not positively associated with increases in caregiver behavior from Time 1 to Time 2. Examining the role of child age in caregiver growth in self-reported behavior and knowledge may be the key to

understanding the applicability of caregiver primary prevention programs across the preschool and first-grade range.

While Child Safe is effective at increasing caregiver knowledge and use of protective behaviors, the range of target population (caregivers of children ages 4-8) may limit its practicality, as children in the pre-school age range (4-5) may require different levels of supervision and communication due to their developmental capacities. Given the underdeveloped social skills of children between the ages of 4-8, it is essential that parents model appropriate behavior and set the foundation for open communication. Children's developmental capacity at the ages of (4-5) includes poor self-regulation skills that often create significant dependence on caregivers for nurturing and care. Children at this age are likely to spend the days at home with family or part –time in preschool. During this stage of a child's life, they begin to test their boundaries and rely on their caregivers to keep them safe (Kraft-Sayre & Pianta, 2000; Margetts, 2002). On the contrary, children from ages 6-8 are more likely to spend time outside the home, spend more time under the supervision of other adults, and have more exposure to technology. At this age, parents begin to encourage more self-sufficiency and independence in their children (e.g. school drop off, sports teams, homework completion). During this developmental time period, children are at an increased risk for both abuse and bullying (Finkelhor et al., 2015; Brassard & Fiorvanti, 2015). Based on the social-behavioral distinctions across the 4-5 and 6-8 age ranges and the impact on parent and child interactions, this study differentiates between preschool children (4-5 years) and school-age children (6-8 years).

The importance of preparing and supporting caregivers during this transition is critical (Kraft-Sayre & Pianta, 2000; Margetts, 2002). While majority of primary prevention programs target elementary children (ages 6-10) (Davis & Gidycz, 2000; Finkelhor, 2009), there is some conflicting beliefs regarding the practicality of providing these programs to children at the pre-school age (3-5 years). Finkelhor (2007) argued that nuanced abuse concepts such as consent may be too complex for pre-school children to understand and that younger children are not physically capable of preventing abuse against most perpetrators. Stuaffer & Deblinger (2004) argued that introducing CSA prevention language to children at a young age can lead to unhealthy beliefs about sexual touch. Children between the ages of 2-8 years think in a black-and-white style which may lead to misconceptions that all touches towards genitalia are bad and/or that a good person (such as a trusted adult) can't engage in a bad touch. Ogden & Hagen (2008) argued that early parent intervention (before 6 years of age) may be best, as parents of younger children are less likely to have a significant history of dysfunctional parent-child interactions and therefore, may be more receptive to behavior training.

Due to both the complexity of sensitive topics like CSA and the differences in developmental expectations between preschool age children (4-5) and school-age children (6-8), caregivers may require differentiated instruction in order to engage them in behavior change. While Child Safe aims to provide evidence-based strategies to caregivers of children across the 4-8 age range, the practicality of a universal approach remains unclear.

Child Age as a Moderator to Parent Training

There is conflicting research regarding whether child age moderates caregiver growth on measurements of knowledge and behavior after parent training. Liggett-Creel et al. (2017) conducted an open-trial study of The Parent University Program (PUP), designed to increase responsive parenting skills for caregivers of children ages 0-3. A sample of 86 parent-child dyads participated in the parenting program. Positive parent behavior was assessed at pre, post, and 2-week follow-up to the intervention. Authors found that while participants demonstrated a significant increase in responsive parenting behaviors, child's age (0-3 range) was associated with the change in responsive parenting (F (2.74) = 7.78, $p < 0.001$, $\eta 2 = 0.17$). Parents of older children scored higher at baseline yet demonstrated less change in behavior over time. Parent behavior change as a result of intervention was moderated by child age. A major limitation of the study is that attendance was not a requirement for completion of the program, resulting in a lack of understanding about whether participant's change in behavior was a direct result of the intervention.

Gubbels et al. (2017) conducted two three-level meta-analyses evaluating 56 school-based child abuse prevention programs. All studies included the effect size of at least one school-based abuse prevention program (or sufficient information to calculate an effect size) and a treatment condition compared to a control condition. Program elements considered in effect size calculations include: children's program related knowledge and children's self-protection skills. Authors found that most school-based programs yielded larger effects when they involved parents (d = 0.932) and when the sample consisted of younger children in preschool or kindergarten (d = 1.529) compared

to elementary school children (d = 0.326). Limitations of the study include: lack of parent measures to assess direct impact of parent involvement, resulting in a lack of understanding as to how child-age impacts parent growth as a result of intervention.

Ogden & Hagen (2008) conducted a RCT of Parent Management Training- The Oregon model (PMTO), designed to teach parents appropriate and effective reinforcement and punishment strategies. A sample of 112 children (ages 4-12 years) with conduct problems and their families were randomized to either PMTO or a regular services referral procedure. Child externalizing problems, child social competence, and parental discipline were assessed at pre and post intervention. Authors found that PMTO was effective in enhancing parental discipline and child age was identified as a moderator for parent treatment outcomes, $F(1,73) = 4.51$, $p = .04$. The findings indicate that outcomes were stronger for children younger than 8, compared to children ages 8-12. The authors conclude that parents of older children presented with greater resistance to change and treatment. The limitations of the study include: lack of clarity and consistency regarding the regular services referral procedure, resulting in confusion as to the significance of the findings.

Current Study

Child Safe for Parents addresses the limitations of existing abuse and bullying prevention programs (e.g., brief, inexpensive, addresses three domains). Research suggests that child age may moderate the effectiveness of intervention programs that caregiver behavior change (Liggett-Creel et al., 2017; Ogden & Hagen, 2008). The influence of child age on caregiver growth on Child Safe knowledge and behavior

assessments has not yet been evaluated but is essential in identifying the practicality of the program.

The aim of this study is to understand the moderating role of child age on the growth of caregiver knowledge and use of protective behavior after attending the Child Safe for Parents workshop. To address this aim, I conducted moderation analyses comparing the change in caregiver knowledge scores and caregiver behavior scores over two time points (baseline and post-Child Safe for Parents) between two distinct caregiver groups, leveled by child age (Level 1: 4-5; Level 2: 6-8).

Hypotheses

Hypothesis 1. Caregivers of older children (6-8 years) will have greater knowledge at baseline than caregivers of younger children (4-5 years).

Hypothesis 2. Caregiver groups will not score significantly different on baseline self-report measures of protective behaviors.

Hypothesis 3. Caregivers of younger children (4-5 years) will demonstrate a greater rate of growth (slope) in self-reported behavior change from baseline to post-child safe for parents than caregivers of older children (5-8 years).

Hypothesis 4. Caregiver groups will not differ on rate of growth (slope) in knowledge change from baseline to post-child safe for parents.

Methodology

Research Design

Data for the study was drawn from a series of open-trials evaluating the effectiveness of Keeping Every Child Safe using an open-trial design, with repeated measures at two time points (baseline and 1-week post Child Safe for Parents). This study focused on the changes in caregiver knowledge and protective behavior from baseline to 1-week post Child Safe for Parents. Child Age was categorized as preschool (4-5 years) and grade-school (6-8), in accordance with prevention research and developmental literature. The current study examines the moderating effect of child age on caregiver change in knowledge and use of protective behaviors.

Inclusion and Exclusion Criteria. Caregivers of a children between the ages of 4 and 8 years old were eligible for participation in this study. Caregiver was defined as a person who regularly provides care and supervision. Examples of caregivers include birth parents, grandparents, and sitters. Inclusion criteria included attendance at the Child Safe for Parents workshop and completion of baseline measures and 1-week post measures. Caregivers were required to speak and understand English and/or Spanish. Caregivers were excluded if they previously participated in the Child Safe for Parents workshop.

Sample. One hundred and five caregivers signed consent and completed baseline assessments. Eighty-four (80%) of those caregivers attended a Child Safe for Parents workshop, and seventy-two (68%) of those participants completed Time 2 assessments. Demographic information of the seventy-two participants used for this study are displayed in Table 1. In our final sample (N = 72), majority of our participants were female (88%), worked full-time (49%), attended and/or graduated college (62%), and

identified English as their primary language (62%). Forty- eight (67%) of caregivers had a participating child in the 4-5 year age-range.

Measures

Measures were administered to caregivers in either English or Spanish. All measures can be found in Appendix B.

Demographic Questionnaire. The demographic questions were adapted from an unpublished demographics form, *PARTNERS Demographic Form-Family Information and Demographic Form* (Brown, E.J. & Sharma-Patel, K.), used in an outpatient mental health clinic. The demographic questionnaire consists of 17 questions on the caregiver and participating child's demographics, including information regarding gender, education, ethnicity/race and profession. Based on previous literature (Wick, 2017; Holland, Malmberg, & Peacock, 2017; Azar & Siegel, 1990), child age was categorized into two groups: preschool (4-5) and grade-school (6-8). Additional demographic variables such as caregiver language and caregiver education were considered as covariates.

Child Safe Parent Knowledge Questionnaire. The Child Safe Knowledge parent questionnaire (Child Safe Knowledge; Brown & Reingold, 2015) is a 26-item multiple-choice test of caregiver knowledge of the content covered in the Child Safe for Parents workshop. Child Safe Knowledge includes questions on prevention strategies to address child sexual abuse, child physical abuse, and bullying. Caregivers were asked to recall evidence-based prevention strategies, identify signs of possible abuse and bullying, and differentiate between effective and ineffective coping skills. Questions on CSA were adapted from a true/false format of a measure designed by Rheingold, Zajac, and Patton

(2012). Questions on both childhood physical abuse and bullying were developed to mirror the CSA questions. Item analysis was conducted on all items to determine the item difficulty level. Items that were deemed too easy (more than 50% correct at baseline) or too difficult (less than 50% correct post workshop) were either removed from the questionnaire or edited (Nunnally & Bernstein, 1994). The Child Safe Knowledge Total Score, which is the percentage correct of the remaining 16 items, was used to assess caregiver knowledge at baseline and post- Child Safe. The Child Safe Knowledge questionnaire yielded a total score with an alpha of .75 at Time 1, demonstrating good internal consistency.

Child Safe Parent Behavior Questionnaire. The Child Safe Behavior parent questionnaire (Child Safe Behavior; Brown, 2015) is a 26-item self-report measure in which caregivers rate the frequency over the past week with which they engaged in protective behaviors introduced in the Child Safe for Parents workshop. Examples of protective behavior assessed are the usage of anatomical names for body parts, the monitoring of children's technology usage, and the engagement in prevention related conversation with children and family members. Items are rated on a scale from 1 (*Never*) to 3 (*3 or more times*). The CSA questions were adapted from the *CSA Prevention Behaviors* measure (Rheingold et al., 2012), and the CPA and bullying items reflect a similar format. The Child Safe Behavior Total Score, which is the sum of frequencies of all 26 Child Safe Behavior items, was used to assess caregiver behavior at baseline and post- Child Safe. Child Safe Behavior yielded a total score with an alpha of .91 at Time 1 demonstrating good internal consistency.

Child Safe for Parents Feedback Questionnaire. The Child Safe for Parents Feedback Questionnaire is an 11-item scale aimed at assessing caregivers' satisfaction with the Child Safe for Parents workshop. Items are rated on a 5-point Likert scale from *Strongly disagree* to *Strongly agree*, with two additional open-ended questions. The feedback questionnaire was adapted from a Rheingold et al. (2015) feedback measure so that it reflected the content and process of Child Safe for Parents.

Intervention

Child Safe for Parents. Child Safe for Parents is a 2.5-hour workshop that consists of three modules: sexual abuse prevention, physical abuse prevention, and bullying prevention. Each module presents (1) facts and statistics around the prevailing problem, (2) evidence-based prevention strategies, and (3) tips and strategies to overcoming both perceptual and concrete barriers to implementation. The CSA prevention module includes prevention strategies such as increasing adult supervision, fostering awareness of those who are interacting with the children, monitoring children's technology, and talking with children about private parts and associated rules. The CPA prevention module introduces parents to CBT techniques such as considering alternative thoughts, modeling appropriate behavior, using stress reduction techniques, and recognizing one's own mistakes. The bullying prevention module encourages parents to model effective communication skills, monitor social interactions, familiarize themselves with the concept of bullying, and to practice strategies that have been found to prevent cyber-bullying. The workshops emphasize caregiver engagement through activities like role-plays, cognitive restructuring, activity scheduling, and through open discussion.

All workshops are led by facilitators who are certified through the Child Safe train-the-facilitator (TTF) program. The TTF program includes completion of relevant readings (including a Facilitator Guide), participation in web-based trainings led by the developers, and observations of Child Safe programming. TTF trainees co-facilitate sessions with the developers and are given feedback. To be certified as facilitators, Trainees are required to facilitate the program to fidelity of at least 90%.

Procedures

Child Safe for Parents was hosted by local organizations within the New York metropolitan area. The organizations consisted of three elementary schools, a daycare center, and one church. Recruitment was led by Child Safe staff with the support of community leaders embedded within the organizations. Flyers and additional documents containing information about the Child Safe program and study were distributed to caregivers of children ages 4-8. Interested caregivers returned contact information directly to the research coordinator via paper slips or email. Potential participants were then contacted by a Child Safe staff member via email or telephone and provided with further information about the study. Eligible caregivers were then asked to fill out consent and baseline measures. Anyone who was unable to complete the forms online was scheduled to complete the measures either in person or over the phone with a staff member.

Assessment and Intervention. Caregiver consent and assessments were completed via the online survey platform Qualtrics, on paper, in-person, or by phone. The Time 1 assessment (baseline) for caregivers consisted of the demographic questionnaire, Child Safe Knowledge, and Child Safe Behavior. Caregivers were provided with a cash

incentive to complete the survey ($10). Caregivers engaged in the 2.5-hour Child Safe for Parents workshop, conducted by one of the trained facilitators. Workshops were offered in the evenings, during afterschool hours, and on weekends, to accommodate caregivers' schedules. Childcare was provided at each workshop. Upon arrival, each caregiver was provided a folder containing a copy of the presentation for note taking, handouts for exercises, a schedule of important dates for the study, as well as a series of mental health and parenting resources. Folders and resources were available in English and Spanish. With the support of a PowerPoint presentation, the facilitator provided oral discourse on the workshop content (in English), with simultaneous Spanish translation when indicated. Time 2 assessments consisted of Child Safe Knowledge and Child Safe Behavior, as well as a feedback questionnaire. Time 2 assessments were completed approximately one week after the Child Safe for Parents workshop using the same procedures described previously. Caregivers were provided with a cash incentive to complete the survey ($20). All participants received reminders via email, text message, and telephone to complete the surveys.

Statistical Analyses. All analyses were conducted using SPSS V 26.0 (IBM corp., 2019). Missing Values Analyses (SPSS) indicated all missing data were missing completely at random (MCAR). Preliminary analyses explored various demographic variables as potential covariates to change in Child Safe Knowledge and Child Safe Behavior scores. Independent samples t-test was used to compare categorical variables with only two levels (e.g. Language) using mean values of Child Safe Knowledge and Child Safe Behavior. For variables with more than two categories (e.g., Education

Status), mean values were compared using ANOVA. Demographic variables associated with scores on Child Safe Knowledge and Child Safe Behavior were used as covariates.

To test my first hypothesis that caregivers of grade-school children (6-8 years) will have significantly higher knowledge at baseline, a *t*-test was conducted with time as the independent variable and total knowledge score as the dependent variable. The same analysis was used to examine the second hypothesis, that there will be no significant difference on Child Safe Behavior at baseline between caregivers of preschool children (4-5 years) and caregivers of grade-school children (6-8 years). To evaluate my third hypothesis, that caregivers of preschool children (4-5 years) will demonstrate a greater rate of growth (slope) in behavior change than caregivers of grade-school children (6-8 years), I conducted a repeated-measures ANOVA with time as the within-subjects variables, child-age as the moderator, and total behavior score as the dependent variable, using a time-by-child-age interaction effect (Figure 3). The same analysis was used to examine the fourth hypothesis (Figure 4), that there will be no significant difference in rate of growth (slope) in knowledge change between caregivers of preschool children (4-5 years) and caregivers of grade-school children (6-8 years). Total knowledge score was the dependent variable. The partial eta squared was calculated to establish the size of the effect of Child Safe for Parents across both outcome variables. A partial eta can be interpreted so that: ≥ 0.01 indicates a small effect size, $\geq .06$ indicates a medium effect size, and ≥ 0.14 indicates a large effect size.

Results

Demographic Variables as Potential Covariates. Demographic variables were assessed to determine their association with the rate of improvement on Child Safe Knowledge and Child Safe Behavior Scores. A univariate linear regression was used to determine the association between Caregiver Language and change in scores on Child Safe Knowledge or Child Safe Behavior. Caregiver Language was associated with change of scores on Child Safe Knowledge F (1, 62) = 36.323, p = <.001, η_p^2 = .381. Caregiver Language was not associated with change of scores on Child Safe Behavior F (1, 66) = .087, p = .769, η_p^2 = .001. Another univariate linear regression was used to determine the association between Caregiver Education and change in scores on Child Safe Knowledge or Child Safe Behavior. Caregiver Education was not associated with changes in Child Safe Knowledge F (1, 62) = .418, p = .521, η_p^2 = .007 or Child Safe Behavior F (1, 66) = 2.755, p = .102, η_p^2 = .042. Demographic variables that were associated with change in scores on Child Safe Knowledge or Child Safe Behavior were utilized as covariates in the moderation models. Figure 1 represents the Time-by-Language interaction for Child Safe Knowledge scores from Time 1 to Time 2. Figure 2 represents the Time-by-Language interaction for Child Safe Behavior scores from Time 1 to Time 2.

Baseline Scores by Child Age level. An independent samples T- tests was used to compare caregiver Knowledge scores across Child Age levels at Time 1. There was no significant effect for Child Age, t (70) = 1.3, p = .093, despite caregivers of children ages 4-5 years (M = 37.02, SD = 18.67) scoring lower than caregivers of children 6-8 years (M = 43.34, SD = 19.60). Another independent samples T- tests was used to compare

caregiver Behavior scores across Child Age levels at Time 1. There was no significant effect for Child Age, t (70) = 1.6, p = .054, despite caregivers of children ages 4-5 years (M = 18.48, SD = 11.05) scoring lower than caregivers of children 6-8 years (M = 22.96, SD = 10.89).

Child Age as a Moderator of Knowledge Scores. A moderation analysis was conducted to evaluate whether Child Age influenced the rate of improvement on Child Safe Knowledge from Time 1 to Time 2, controlling for Caregiver Language. Using a repeated measure ANOVA with Time as the within-subjects variable, Child Age as the between-subjects variable, Caregiver Language as a covariate, and Child Safe Knowledge as the dependent variable, there was no significant interaction effect of Time-by-Child Age (Table 2). There was a main effect of Time and a main effect of Caregiver Language. There was not a main effect of Child Age. Child Safe Knowledge was lower at Time 1 than Time 2. Caregiver's whose primary language was English scored higher on Child Safe Knowledge than their Spanish-speaking peers.

Child Age as a Moderator of Behavior. A second moderation analysis was conducted to evaluate whether Child Age influenced the rate of improvement on Child Safe Behavior from Time 1 to Time 2. Using a repeated measure ANOVA with Time as the within-subjects variable, Child Age as the between-subjects variable, and Child Safe Behavior as the dependent variable, there was no significant interaction effect of Time-by-Child Age (Table 3). There was a main effect of Time. There was not a main effect of Child Age. Child Safe Behavior was lower at Time 1 than Time 2.

Post-Hoc Analyses. To gain further understanding of the role of language on caregiver performance across behavior and knowledge measures, language was looked at

as a moderator for caregiver program satisfaction. There was a significant effect for Caregiver Language, t (43) = 2.19, p = .017, with English speaking caregivers (M = 49.89, SD = 4.46) scoring higher on Satisfaction than Spanish speaking caregivers (M = 46.41, SD = 6.22).

Discussion

Keeping Every Child Safe is a prevention program aimed to equip caregivers with the knowledge and skills needed to protect their children from abuse and bullying. This study aimed to make steps towards addressing a long-contested question in prevention research; is it ever too early to intervene? Using an open-trial design, 72 caregivers with children ages 4-8 were assessed on knowledge and behavior before and after attending the Child Safe for Parents workshop to determine the influence of child-age on caregiver improvement. There were two primary hypotheses in this study. The first, caregivers of older children (ages 6-8) and caregivers of younger children (ages 4-5) would respond to the Child Safe programing at a similar rate on measurements of knowledge. The second, after participating in Child Safe, caregivers of younger children (ages 4-5) would demonstrate a greater rate of growth on self-report measurements of protective behaviors.

Supporting the pilot randomized controlled trial on Keeping Every Child Safe (Brown, Beekman, & Canter, 2017), caregivers in the current study made significant gains in both knowledge and behavior. Caregivers across age-levels scored similarly on measurements of knowledge and behavior at baseline. Caregivers of the younger children scored an average of 47% correct on measurements of knowledge while caregivers of the older children scored an average of 51%, indicating that gaps in prevention knowledge are similar across caregivers of preschool and school-aged children. Likewise, there was no significant difference between caregivers' knowledge or self-reported use of protective behaviors after attending the workshop, suggesting that the developmental stage of a child within the 4-8 age range may not play a role in a caregiver's ability to retain protective knowledge or engage in protective behaviors.

Results of the moderation analyses indicate that the age of the child did not predict the rate of growth on knowledge or behavior measures. This is inconsistent with previous studies that found that parents of older children were more resistant to change in behavior after intervention (Liggett-Creel et al. 2017; Ogden & Hagen 2008). What differentiates Child Safe from other programs that were not as successful with younger children are both content and delivery. Unlike other parenting programs, Child Safe includes a discussion of concrete and perceptual barriers to using the skills that are taught. This maximizes the likelihood of behavior change (Smokowski et al., 2018)). In addition, consistent with research findings of best practices in training (Adams, Tallon, & Rimell, 1980; Delgado & Lutzker, 1988), Child Safe for Parents is interactive, with discussions, roleplays, and practical tools that are easily implemented. Another difference between the current study and those in which there were significant differences by child age was the age range of targeted children. The targeted age-range in Ligget-Creel et al. (2017) was 0-3 years-old and in Ogden and Hagen (2008) was 4-12 years-old. By targeting caregivers of children in a developmentally similar age range (4-8 years-old), Child Safe was able to provide parent training that was generalizable across age-levels. Specifically, providing caregivers with time to create a concrete plan for implementation allowed them to overcome perceived barriers relevant to child-age, such as identifying age-appropriate language to use, brainstorming questions their child might ask, and preparing their responses.

One strength of the current study is that we included a diverse caregiver sample, often unseen in prevention research. Our participants varied in both primary language and educational achievement. In our sample, 16% percent earned graduate degrees and 15%

earned less than a high school diploma. In addition, 38% were primarily Spanish speaking and 62% were primarily English speaking. We included caregiver language as a covariate because we found that Spanish-speaking caregivers scored lower than English-speaking caregivers on child safe knowledge measures at baseline. This is consistent with previous studies that found that Hispanic/Latine parents have less knowledge of childhood prevention topics (Prikhidko & Kenny, 2021). In turn, the Spanish-speaking caregivers showed less improvement in prevention knowledge than English-speaking caregivers. These differences were not found in our behavior measures. Differences in knowledge acquisition between English-speaking and Spanish-speaking caregivers may be attributed to both cultural and practical components of Child Safe. Previous prevention studies found that nuances in the translation of prevention topics may interfere with Spanish-speaking caregiver's ability to comprehend prevention material (Cowgill et al., 2014). It is possible that our Spanish-speaking participants understood the behaviors asked of them but had difficulty understanding the reasoning behind the behavior change, assessed in the knowledge measures. Additionally, our Spanish-speaking caregivers had less formal education than our English-speaking caregivers, with 39% earning less than a High School Diploma, 31% earning a High School Diploma, and 15% attending at least some college. It is possible that the Child Safe workshop materials were too difficult to read for our average Spanish-speaking participants.

Implications

Practicality. The finding that rates of improvement in knowledge and behavior were not influenced by child age have important implications for public policy and primary prevention practices within our education system. The lack of difference in

outcomes between caregivers of pre-school versus early elementary age children challenges the argument that children must be of a certain age for caregivers to benefit from prevention training. By introducing knowledge and behavioral strategies that can be easily adopted by caregivers across a child's lifespan, Child Safe helps caregivers overcome their fears regarding the developmental appropriateness of parent-child discussions surrounding sensitive topics such as abuse and bullying. Child Safe demonstrates that providing opportunity for parents to address both actual and perceived barriers to implementation of protective behaviors through evidence-based strategies such as psychoeducation and in-session role-play (Holden, Brown, Baldwin, & Croft Caderao, 2013; Kaminski, Valle, Filene, & Boyle, 2008) may help overcome these barriers. Specifically, by utilizing *in-vivo* practice, scheduling, and cognitive-restructuring, Child Safe engages caregivers in discussion and activities that are equally as applicable to caregivers of younger and older children.

Policy. By demonstrating that Child Safe is applicable to caregivers with children ages 4-8, we open the dialogue for altering public policies that target children of a specific age range. States that adopted Erin's Law, for example, require public schools to provide education on sexual abuse prevention to students in kindergarten through twelfth grade. Reflecting on our findings in conjunction with previous research establishing that repeated exposure to prevention strategies is associated with better learning and the economic cost of abuse/bullying (Davis & Gifycz, 2000), we should offer prevention programing early and repeatedly to caregivers.

Generalizability. Resistance to universal prevention efforts note concern regarding applicability to minority samples (Dumas et al., 2015; Parra-Cardona et al.

2016). Both our Spanish-speaking and English-speaking caregivers made significant gains in knowledge and behavior, however, our English-speaking caregivers demonstrated significantly more growth on measurements of knowledge compared to our Spanish speaking caregivers. Our English-speaking caregivers reported to be significantly more satisfied with Child Safe than our Spanish-speaking caregivers, indicating that translation alone may not be enough to reach Spanish-speaking communities. Caregivers may benefit from a cultural-specific session that focuses on addressing cultural themes (i.e., immigration and biculturalism) that may influence their parenting, and in turn, increase program relatability and overall satisfaction (Parra-Cardona et al. 2016). The adaption of culturally tailored content in dual-lingual programing may be the next step in prevention programming, and specifically, Child Safe.

Implications for School Practice

In demonstrating that Child Safe is applicable to caregivers of children 4-8, we provide a cost-effective opportunity for schools to collaborate in prevention efforts. Several states have already passed legislation mandating schools to provide prevention programing targeting adverse childhood experiences such as abuse and bullying. There are many prevention programs available, all varying in cost and content. Child Safe provides a comprehensive program that can be used across the 4-8 age range and addresses multiple prevention topics, therefore minimizing the cost for schools. By including a training program that allows school professionals to become facilitators, Child Safe creates an opportunity for a sustainable prevention program embedded within the school that is not reliant on outside partners. School psychologists are one of many school employees that could benefit from becoming a Child Safe facilitator, as a key

component of their role at a school is overseeing and sometimes implementing prevention efforts.

Limitations

There are several methodological limitations within this study that limit the generalizability of the findings. The first set of limitations relate to the research design. This study used an open-trial design without randomization. The lack of a control group limits our ability to attribute growth in knowledge and behavior directly to caregivers' participation in Child Safe. There is a chance our participants learned prevention information from other resources outside of the Child Safe workshop which may have influenced their change in scores. The test-retest design also increases the risk of score inflation post-workshop due to exposure to the multiple-choice questions rather than a reflection of an increase in knowledge and skill acquisition. Lastly, our study only included participants who completed both pre- and post- measures and attended Child Safe for Parents. Not including caregivers who completed baseline measures but dropped out of the study prior to attending the workshop, and those who completed baseline measures, attended the workshop, but failed to complete post-measures were not included in the analyses. Not including data collected from these participants may have created bias in our data and limits the generalizability of our findings.

In addition to limitations due to research design, generalizability is limited due to participant characteristics. Our sample size was small ($N = 72$) which limits the power of our statistical findings and increases the risk that our findings are a result of confirmation bias (i.e., our participants were more likely to respond positively to our workshop based on pre-existing traits such as prior interest in prevention topics). Our limited sample also

led to unintentional differences between groups. Specifically, educational experience varied between English- and Spanish-speaking caregivers. Although we consider our diverse sample of caregivers a strength of our study, the differences between caregiver groups at baseline make it difficult to draw meaningful interpretations from our findings.

Finally, the validity of our outcome measures limits interpretation of our findings. Our behavior measures relied on caregivers' self-report, not direct observation, making our data vulnerable to subject bias. There is a chance that participants reported higher use of protective behaviors in either conscious or subconscious effort to act in a way that pleased the researchers. Additionally, the surveys were tested for validity in English, but not in Spanish.

This study is not without strengths. Prevention research has historically focused on white, European-descent populations, although the need to extend programing to the minority population is well documented (Mendez, 2010; Parra-Cardona et al., 2016; Dumas, Arriaga, Begle, & Longoria, 2010). Our study directly addressed barriers to engagement commonly reported by minority caregivers, such as time-restraints, child-care, and language. These findings highlight the feasibility of recruitment of minority caregivers in prevention research.

Future Research Recommendations

Future research on Child Safe should focus on addressing the limitations identified in this study. To address the methodological limitations, a randomized controlled trial (RCT) is warranted. The RCT should include data collected over three time points to better assess whether caregivers retained the knowledge and use of protective behaviors over time and whether the retention of those skills were influenced

by child age. To address the limitations of the sample, recruitment for the RCT should focus on engaging a larger, socio-economically diverse sample that better represents the general population. To address the limitations identified in our measurements, Spanish measures should be assessed for validity and further consultation with Spanish-speaking professionals may be warranted. Program fidelity across language delivery should be examined for nuances in translation during programing. An examination of the caregivers who dropped out of the study may provide important information regarding the accessibility and feasibility of the program to the general population.

Appendix A. Tables and Figures

Table 1.
Participant Demographic Characteristics

	All Participants	Spanish Speaking	English Speaking
	N (72)	N (28)	N (44)
Variable	*M (SD)*	*M (SD)*	*M (SD)*
Caregiver Age in Years	39 (11)	35 (7)	41 (11)
Child Age in Years	5 (1)	2 (1)	2 (1)
Variable	*n (%)*	*n (%)*	*n (%)*
Primary Language			
English	42 (62)	-----	-----
Spanish	26 (38)	-----	-----
Ethnicity			
Hispanic or Latino/a	32 (47)	26 (100)	6 (14)
Non-Hispanic or Latino/a	36 (53)		36 (86)
Race			
African American/Black	4 (6)		4 (10)
Caucasian	20 (28)		20 (47)
Multi-racial	3 (4)		3 (7)
Hispanic- White	5 (7)	3 (12)	2 (5)
Hispanic- Unspecified	25 (37)	22 (85)	3 (7)
American Indian	5 (7)	1 (4)	4 (10)
East Asian	3 (4)		3 (7)
South Asian	5 (3)		2 (5)
Native Hawaiian or Pacific	1 (2)		1 (2)
Caregiver Gender			
Female	60 (88)	21 (81)	39 (93)
Male	8 (12)	5 (19)	3 (7)
Child Gender			
Female	35 (52)	16 (62)	19 (45)
Male	33 (49)	10 (39)	23 (55)
Employment			
Full-time	33 (49)	9 (35)	24 (57)
Part-time	12 (18)	7 (27)	8 (19)
Homemaker	16 (24)	10 (39)	6 (14)
Unemployed	2 (3)		3 (7)
Other	5 (7)		
Education Attainment			
Less than HS Diploma	10 (15)	10 (39)	
High School Diploma/GED	12 (18)	8 (31)	4 (9.5)
Some college	15 (22)	4 (15)	11 (26)
College Degree	16 (24)	1 (4)	15 (36)
Graduate Degree	11 (16)		11 (26)

Note: Demographic data displayed is representative of the seventy-two caregivers who completed both Time 1 and Time 2 assessments and attended Child Safe for Parents Workshop.

Table 2. Association between Language and Caregivers' Change in Knowledge Over Time.

Variable	Level	Knowledge			
		M (*SD*)	*F*	*p*-value	η_p^2
Time	Time 1	40.24 (19.45)	18.23	<.001	.233
	Time 2	55.63 (21.79)			
Language	English	66.76 (15.73)	49.67	<.001	.453
	Spanish	33.4 (15.95)			
Time x Language	English Time 1	45.24 (19.44)	6.08	.017	.092
	Spanish Time 1	29.52 (14.12)			
	English Time 2	66.76 (15.73)			
	Spanish Time 2	35.41 (15.95)			

Note. Results are reflective of a repeated measure ANOVA. Language refers to caregivers' primary language identified in the demographic's questionnaire. Knowledge refers to caregivers Child Safe Knowledge Total Score.

Table 3. Moderating Effect of Child Age in Knowledge Scores, Covarying Language

Variable	Level	Knowledge			
		M (*SD*)	*F*	*p*-value	η_p^2
Time	Time 1	40.24 (19.45)	251.268	<.001	.810
	Time 2	55.63 (21.79)			
Language	English	56.70 (16.53)	40.135	<.001	.405
	Spanish	32.1 (22.04)			
Child Age	4-5 Years	46.80 (16.97)	1.022	.316	.017
	6-8 Years	50.70 (27.15)			
Time x Child Age	4-5 Years Time 1	38.19 (18.09)	.842	.362	.014
	6-8 Years Time 1	45.28 (22.19)			
	4-5 Years Time 2	50.76 (22.77)			
	6-8 Years Time 2	67.55 (13.38)			

Note. Results are reflective of a repeated measure ANOVA with Time as the within-subjects variable, Child Age as the between-subjects variable, caregiver Language as a covariate, and Child Safe Knowledge as the dependent variable.

Table 4. Moderating Effect of Child Age in Behavior Scores

Variable	Level	Behavior			
		M (*SD*)	*F*	*p*-value	η_p^2
Time	Time 1	19.62 (11.39)	562.324	<.001	.898
	Time 2	30.62 (11.89)			
Child Age	4-5 Years	24.57 (11.68)	.660	.420	.010
	6-8 Years	26.310 (11.78)			
Time x Child Age	4-5 Years Time 1	18.36 (11.34)	1.022	.316	.016
	6-8 Years Time 1	22.33 (11.29)			
	4-5 Years Time 2	30.78 (11.93)			
	6-8 Years Time 2	30.29 (12.09)			

Note. Results are reflective of a repeated measure ANOVA with Time as the within-subjects variable, Child Age as the between-subjects variable, and Child Safe Behavior as the dependent variable.

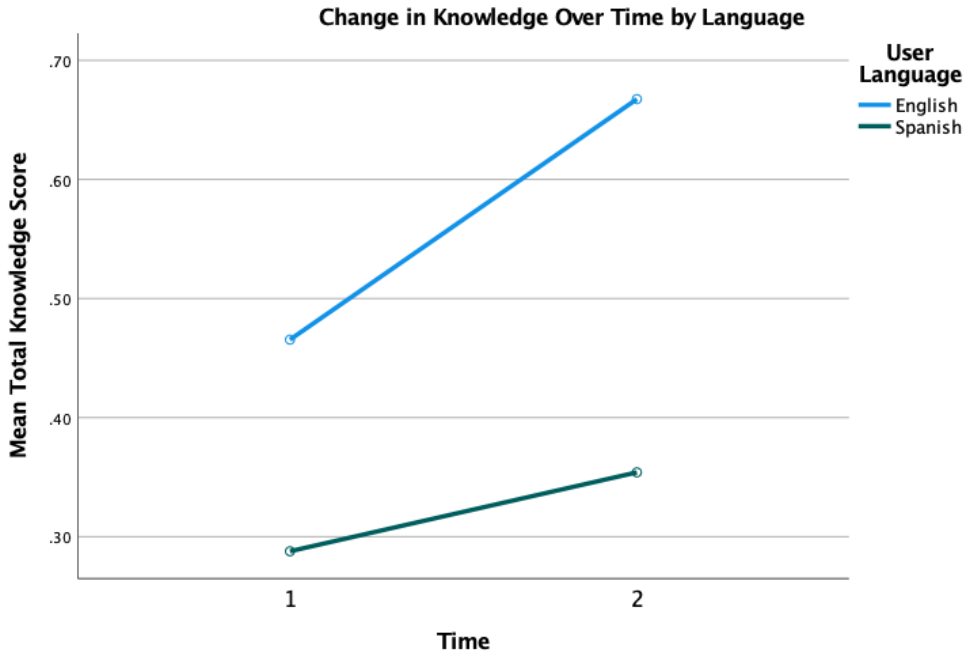

Figure 1. Change in caregiver Knowledge scores from Time 1 to Time 2 differentiated by caregiver Language.

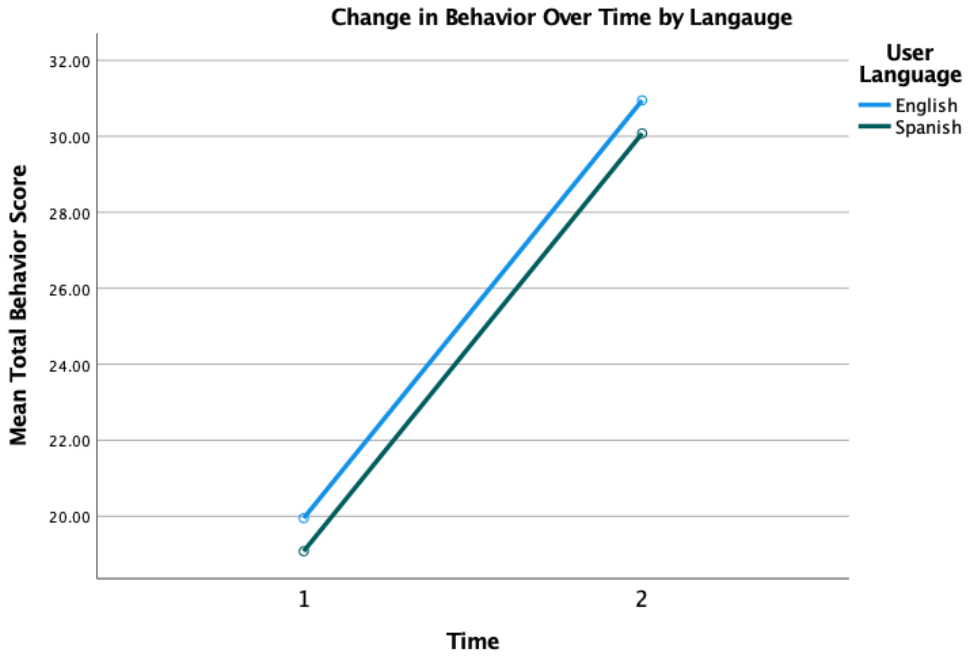

Figure 2. Change in caregiver Behavior scores from Time 1 to Time 2 differentiated by caregiver Language.

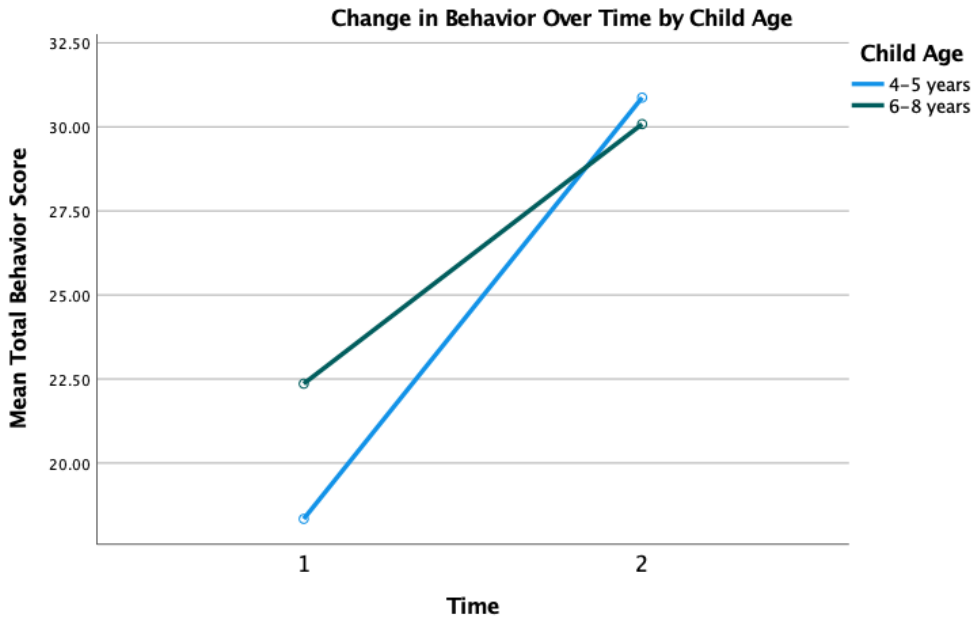

Figure 3. Change in caregiver Behavior scores from Time 1 to Time 2 differentiated by Child Age Level

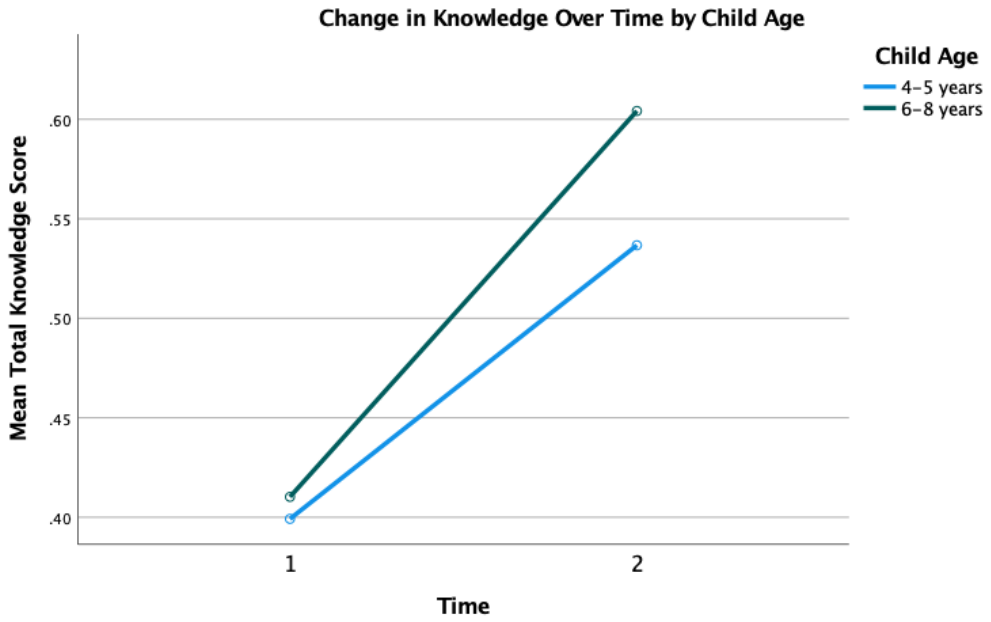

Figure 4. Change in caregiver Knowledge scores from Time 1 to Time 2 differentiated by Child Age Level, covaried by caregiver Language.

Appendix B. Assessments

Demographic Questionnaire

Please answer the following questions. Thank you!

Do you work with children and/or have regular contact with children through your job?

- ○ Yes
- ○ No

Which of the following best describes your interaction with children in the past 6 months? Check all that apply:

- ☐ I supervise those who work or volunteer with children.
- ☐ I am paid to work with children under the age of 18 (includes substitute teaching).
- ☐ I work with children through an internship.
- ☐ I volunteer with children under the age of 18.
- ☐ I am a primary caregiver of children under the age of 18.
- ☐ I have extensive contact with children under the age of 18 in my family or social circle.
- ☐ Other (please specify): _____

Including all the choices you indicated above, how many children would you say you interacted with in total during the past six months? _____

Do you have any children living with you?

- ○ Yes
- ○ No

Please write your age: _____

What is your gender?

- ○ Male
- ○ Female

What is the last grade or year in school you completed?

- ○ 11th grade or less
- ○ 12th/GED/High School Diploma
- ○ Some college
- ○ College graduate
- ○ Master's degree
- ○ Doctoral degree

What is your employment status?

- ○ Employed full-time (please list your profession):_____
- ○ Employed part-time (please list your profession): _____
- ○ Student
- ○ Homemaker
- ○ Unemployed/looking for a job
- ○ Other (please specify): _____

Which of the following categories best describes your race (choose all that are appropriate)?

- ☐ African American/Black
- ☐ Caribbean American
- ☐ American Indian or Alaska Native
- ☐ East Asian (e.g., Chinese, Korean, Japanese)
- ☐ South Asian (e.g., Indian, Pakistani, Bangladeshi)
- ☐ Caucasian or White
- ☐ Middle Eastern (specify country): _____
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other (please specify): _____

Which of the following best describes your ethnicity (choose one, regardless of race)?

- ○ Hispanic or Latino/a
- ○ Non-Hispanic or Latino/a

What is the language spoken at your home or your preferred language?

- ○ English
- ○ Spanish
- ○ Other: _____

Please enter your email address. _____

Please enter your telephone number: _____

Please answer the following questions about the child participating in this study with you:

What is the child's gender?

- ○ Male
- ○ Female

What is the Child's Age?

- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8

Which of the following categories best describes the child's race (choose all that are appropriate)?

- ☐ African American/Black
- ☐ Caribbean American
- ☐ American Indian or Alaska Native
- ☐ East Asian (e.g., Chinese, Korean, Japanese)
- ☐ South Asian (e.g., Indian, Pakistani, Bangladeshi)
- ☐ Caucasian or White
- ☐ Middle Eastern (specify country): _____
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other (please specify): _____

Which of the following best describes the child's ethnicity (choose one, regardless of race)?

- ○ Hispanic or Latino/a
- ○ Non-Hispanic or Latino/a

Cuestionario Demográfico

Por favor, responde a las siguientes preguntas. ¡Gracias!

]Ud. trabaja con niños y/o tiene contacto regular con niños a través de su trabajo?

- ○ Sí
- ○ No

Cuáles de las siguientes frases mejor describe su interacción con niños durante los seis meses pasados? Seleccione todas las que apliquen:

- ▢ Superviso gente que trabaja o sirve como voluntario/a con niños.
- ▢ Me pagan por trabajar con niños menores de 18 años. (Incluye como profesor(a) suplente).
- ▢ Trabajo con niños como un requisito de mis estudios. (Incluye como práctica).
- ▢ Sirvo como voluntario/a con niños menores de 18 años.
- ▢ Soy el cuidador principal de uno o mas niños/as menores de 18 años (incluye a padres).
- ▢ Tengo contacto extenso con niños menores de 18 años en mi familia o en mi círculo de amistades.
- ▢ Otra (especifique por favor) _____

Incluyendo todas las elecciones que Ud. indicó arriba, ¿con cuántos niños interactuó usted durante los últimos seis meses?_____

Hay niños que viven con Ud.?

- ○ Sí
- ○ No

Por favor, escribe cuántos años tiene Ud.: _____

Cuál es su género? (Elige uno)

- ○ Masculino
- ○ Femenino

¿Cuál fue el nivel más alto en la escuela que completó?

- ○ Grado 11 o menos
- ○ Grado 12/ GED/ Graduado con titulo secundaria
- ○ Algunos años en la universidad
- ○ Licenciado universitario
- ○ Maestría
- ○ Doctorado

Cual es su situación de empleo?

- ○ Empleado de tiempo completo, cual es su profesión? (full-time) _____
- ○ Empleado a tiempo parcial, cual es su profesión? (part-time)_____
- ○ Estudiante

- ○ Ama de casa
- ○ Desempleado/ buscando trabajo
- ○ Otra (especifique por favor): _____

Cuáles de las categorías siguientes mejor describe su raza de origen (seleccione todos los que son apropiados)?

- ☐ afroamericano /negro
- ☐ afro caribe
- ☐ amerindio o nativo de Alaska
- ☐ asia oriental (por ej., chino, coreano, japonés)
- ☐ asia del sur (por ej., indio, paquistaní, bangladeshí)
- ☐ caucásico o blanco
- ☐ del medio oriente (país especifico):_____
- ☐ nativo hawaiano o otra isleños del pacifico
- ☐ otra (especifique): _____

Cuáles de las categorías siguientes mejor describe su etnicidad (elige una, sin tomar en cuenta su raza)?

- ○ Hispáno/a o Latino/a
- ○ No Hispáno/a o Latino/a

Cuál es la idioma que mas hablan en casa o que idioma prefiere?

- ○ ingles
- ○ español
- ○ otro (especifique): _____

Por favor, pone su email._____

Por favor, pone su numero de teléfono:_____

Por favor, responde a las preguntas siguientes sobre el/la niño/a está participando en este estudio con usted:

¿Cual es el género de niños?

- ○ Masculino
- ○ Femenino

Cuantos anos tiene el/la niño/a?

- ○ 4
- ○ 5
- ○ 6
- ○ 7
- ○ 8

¿Cuáles de las categorías siguientes mejor describe su raza de origen del/la niño/a (seleccione todos los que son apropiados)?

- ☐ afroamericano /negro
- ☐ afro caribe
- ☐ amerindio o nativo de Alaska
- ☐ asía oriental (por ej., chino, coreano, japonés)
- ☐ asía del sur (por ej., indio, paquistaní, bangladeshí)
- ☐ caucásico o blanco
- ☐ del medio oriente (país especifico):_____
- ☐ nativo hawaiano o otros isleños del pacifico
- ☐ otra (especifique): _____

¿Cuáles de las categorías siguientes mejor describe su etnicidad del/la niño (elige una, sin tomar en cuenta su raza)?

- ○ Hispano/a o Latino/a
- ○ No Hispano/a o Latino/a

Child Safe Parent Knowledge Questionnaire

Please answer all of the following question by picking the one best answer.

1. When children are using the internet, parents should look at what they are viewing:

- ○ a. The entire time
- ○ b. At random, unpredictable times
- ○ c. When on certain websites (e.g., facebook, instagram)
- ○ d. Not at all because it is an invasion of privacy
- ○ e. I don't know

2. If you are trying to protect your children from sexual abuse and you are taking them to a party where there will be family and friends, what would be important to tell them?

- ○ a. “You have to be nice to everyone.”
- ○ b. “Take care of each other.”
- ○ c. “You don’t have to hug or kiss anyone except our family.”
- ○ d. “You can pick how you want to greet everyone.”
- ○ e. I don't know

3. What would be the best time to discuss sexual abuse with your child?

- ○ a. While driving carpool to sports practice
- ○ b. While playing a board game as a family
- ○ c. While bathing/showering your child
- ○ d. While watching a television show with your child
- ○ e. I don't know

4. What does DEFEND (an acronym to protect against sexual abuse) stand for?

- ○ a. Demand to know who your child is hanging out with at all times, Encourage your child to ask questions, Follow your gut, Empower your children, No closed door policy, and Discuss the dangers of technology
- ○ b. Demand an open door policy, Empower your child, Follow your gut, Examine your child’s technology, No secrets, and Discuss sexual abuse prevention

○ c. Discuss sexual abuse, Examine your child's friends, Follow your intuition, Encourage them to talk to their friends about sexual abuse, No talking to strangers, and Do not worry who your child plays with

○ d. Demand an open door policy, Encourage questions about sexual abuse, Find out everything you can on signs of sexual abuse, Examine your child's technology, (K)Now who your child is hanging out with, and Discuss sexual abuse

○ e. I don't know

5. One of the ways in which caregivers can protect against sexual abuse is by demanding an open-door policy. What is an open-door policy?

○ a. When the caregiver can talk to any other adult in the child's life at any time

○ b. Having your child keep their door open at all times

○ c. Being able to drop in unexpectedly on any child-care provider

○ d. Allowing the child to enter any room in the house at any time

○ e. I don't know

6. Why is it important for caregivers to use the word "private" instead of "secret" when communicating with their children about personal experiences?

○ a. Children may not know how to keep a secret

○ b. Private means that no one should talk about upsetting things outside the family

○ c. Secret is a term that abusers use to get children not to tell

○ d. The fact that the child and abuser know each other is often a secret

○ e. I don't know

7. If a child disclosed that s/he was abused, what would you do *first*?

○ a. Give the child a hug

○ b. Call the police

○ c. Act calm so the child isn't frightened

○ d. Take 5 minutes away from the child to process anger and fear

○ e. I don't know

8. Caregivers are likely to lose their cool when:

○ a. They have spent a lot of time with their child

○ b. They have spent very little time with their child

○ c. Their child has a developmental delay

○ d. They believe that their child is misbehaving to make them angry

○ e. I don't know

9. What does CARE (an acronym to help prevent physical abuse) stand for?

○ a. Consider alternative thoughts, Avoid stressful situations, React to the situation appropriately, and Educate other parents

○ b. Create fun times, Avoid stressful situations, Read about parenting, and Educate your child

○ c. Consider alternative thoughts; Act to improve children's behaviors; Reduce anger, anxiety, and stress; and Errors are teaching moments

○ d. Create fun times, Act to improve children's behavior, Read about abuse, and Each family is different

○ e. I don't know

10. When Tom gets up to give his report in class, Sarah and her friends start calling Tom names. Everyone can hear but the teacher. Sarah and her friends do this every time Tom speaks in class or raises his hand. This is an example of which form of bullying?

○ a. Physical

○ b. Verbal

○ c. Indirect

○ d. School-based

○ e. I don't know

11. What should a parent do if their child is being bullied?

○ a. Explain that bullying is a part of growing up and will pass

○ b. Confront the parents of the bully directly

○ c. Help find activities to build self esteem

○ d. Tell the child to work it out with the bully

○ e. I don't know

12. What does MODEL (an acronym to help prevent bullying) stand for?

○ a. Model healthy romantic relationships, Observe social interactions, Discuss bullying of siblings, Encourage self-esteem, and Listen to your child

○ b. Make use of respectful communication, Only watch out for your child, Discuss bullying of siblings, Empathize, and Listen to children in need

○ c. Memorize the definition of bullying, Omit bullying from home, Demand your child not bully others, Examine your child's friends, and Learn to prevent cyber-bullying

○ d. Make use of respectful communication, Observe social interactions, Define bullying and your expectations, Empower all involved, and Learn to prevent cyber-bullying

○ e. I don't know

13. Which thinking pattern is NOT associated with the use of harsh discipline?

○ a. Believing that the child is misbehaving on purpose

○ b. Believing that a child should be able to do something that s/he isn't doing

○ c. Thinking of other explanations for a child's behavior

○ d. Feeling depressed myself

○ e. I don't know

14. When your child has misbehaved and you are deciding how to punish him/her, what is the *first* question to ask yourself?

○ a. "Who else can handle this?"

○ b. "What am I feeling right now?"

○ c. "Why did she do that?"

○ d. "What do I want her/him to learn right now?"

○ e. I don't know

15. When discussing sexual abuse prevention with your child, you should:

○ a. Explain the function of each private part

- ○ b. Use the terms for private parts that they see on television
- ○ c. Explain sex to your child
- ○ d. Use anatomically-correct terms
- ○ e. I don't know

16. For apps that require your child to have a password, the most important thing is that you:

- ○ a. Ask your child to show you what s/he does on the site
- ○ b. Know the password and check the site
- ○ c. Tell your child to write down the password so s/he doesn't forget it
- ○ d. Pick the password
- ○ e. I don't know

Cuestionario de conocimiento del padre de Child Safe

Por favor, responde a todas las siguientes preguntas.

1. Cuando los niños usan Internet, los padres deben mirar lo que están viendo:
   - ○ a. Todo el tiempo.
   - ○ b. Al azar, tiempos imprevisibles.
   - ○ c. Cuando en ciertos sitios web (por ejemplo, Facebook, Instagram).
   - ○ d. En absoluto porque es una invasión de la privacidad.
   - ○ e. No lo sé.

2. Si está tratando de proteger a sus hijos/as del abuso sexual y los está llevando a una fiesta donde habrá familiares y amigos, ¿qué sería importante decirles?
   - ○ a. "Tienes que ser amable con todos."
   - ○ b. "Cuida unos de otros."
   - ○ c. "No tienes que abrazar ni besar a nadie excepto a nuestra familia."
   - ○ d. "Puedes elegir cómo quieres saludar a todos."
   - ○ e. No lo sé.

3. ¿Cuál sería el mejor momento para hablar sobre el abuso sexual con su hijo/a?
   - ○ a. Al ir a la práctica deportiva.
   - ○ b. Mientras juegas un juego de mesa con familia
   - ○ c. Mientras está bañando/ duchando a su hijo/a.
   - ○ d. Mientras está viendo un programa de televisión con su hijo/a.
   - ○ e. No lo sé

4. ¿Que significan las letras de DEFEND (un acrónimo para proteger contra el abuso sexual)?
   - ○ a. Exija saber con quién está su hijo/a en todo momento, Anime a tu hijo/a a hacer preguntas, Sigue su intuición, Capacite a sus hijos, No hay política de puertas cerradas, y Hable con su hijo/a de los peligros de la tecnología.
   - ○ b. Exija una política de puertas abiertas, Capacite a sus hijos, Sigue su intuición, Examina la tecnología de su hiño/a, No hay secretos, y Discuta la prevención del abuso sexual.
   - ○ c. Discuta el abuso sexual, Analice a los amigos de su hijo/a, Sigue tu intuición, Anime a su hijo/a a hablar con sus amigos sobre el abuso sexual, No hablar con desconocidos, y No preocúpese de con quién juega su hijo/a.
   - ○ d. Exija una política de puertas abiertas, Anime a su hijo/a a hacer preguntas sobre el abuso sexual, Aprende todo lo que pueda sobre de los signos de abuso sexual, Examine la tecnología de tu hijo/a, Sepa con quién anda su hijo/a, y Discuta el abuso sexual.
   - ○ e. No lo sé.

5. Una de las maneras que los cuidadores pueden proteger a los niños contra el abuso sexual es exigir una política de puertas abiertas. ¿Qué es una política de puertas abiertas?
   - ○ a. Cuando el cuidador puede hablar con cualquier otro adulto en la vida del niño en cualquier momento.
   - ○ b. Que su hijo/a mantenga su puerta abierta en todo momento.
   - ○ c. Ser capaz de ingresar inesperadamente en cualquier proveedor de cuidado infantil.
   - ○ d. Permitiendo al niño a entrar a cualquier habitación de la casa en cualquier momento.
   - ○ e. No lo sé.

6. ¿Por qué es importante que los cuidadores de niños utilicen la palabra "privado" en lugar de "secreto" cuando se comunican con sus niños/as sobre de experiencias personales?
   - ○ a. Los niños no saben cómo guardar un secreto.
   - ○ b. Privado significa que nadie debe hablar de cosas perturbadoras fuera de la familia.
   - ○ c. El secreto es un término que usan los abusadores para que los niños no digan nada.
   - ○ d. A menudo, el hecho de que el niño y el abusador se conocen es un secreto.
   - ○ e. No lo sé.

7. ¿Cuál es el primer paso si su niño/a revele que él o ella fue físicamente o sexualmente abusada?
   - ○ a. Dale un abrazo al niño
   - ○ b. Llame a la policía.
   - ○ c. Mantenga la calma para evitar que su niño/a se asuste.
   - ○ d. Tome 5 minutos de distancia del niño para procesar ira y temor.
   - ○ e. No lo sé.

8. Los cuidadores de niños son más propensos a perder la calma cuando:
   - ○ a. Han pasado mucho tiempo con sus hijos/as.
   - ○ b. No han pasado mucho tiempo con sus hijos/as.
   - ○ c. Su niño/a tiene un retraso en el desarrollo.
   - ○ d. Creen que su niño/a está comportándose mal para enojarlos.
   - ○ e. No lo sé.

9. ¿Qué significa CARE (un acrónimo para prevenir el abuso físico)?
   - ○ a. Considera Pensamientos Alternativos, Evita situaciones que causan el estrés, Reacciona a la situación de forma adecuada, Educa a otros padres.
   - ○ b. Crea momentos divertidos, Evita situaciones estresantes, Lee acerca de la crianza de los hijos, y Educa a su hijo/a.

- ○ c. Considera Pensamientos Alternativos, Actúa para mejorar el comportamiento de su hijo/a, Reduzca la ira, la ansiedad, y el estrés, y Los errores son momentos de enseñanza.
- ○ d. Crea tiempos divertidos, Actúa para mejorar el comportamiento de su hijo/a, Lee sobre el abuso, y Cada familia es diferente.
- ○ e. No lo sé.

10. Cuando Tom se levanta a dar su presentación en clase, Sarah y sus amigos empiezan a insultar a Tom. Todos, salvo el profesor, lo escuchan. Sarah y sus amigos hacen esto cada vez que Tom habla en clase o se levanta su mano. ¿Esto es un ejemplo de que tipo de “bullying"?
    - ○ a. Físico
    - ○ b. Verbal
    - ○ c. Indirecto
    - ○ d. Escolar
    - ○ e. No lo sé.

11. ¿Qué debe hacer un padre si su hijo esté siendo intimidado/a (bullied)?
    - ○ a. Explicar que “bullying” es una parte de crecer y que va pasar.
    - ○ b. Enfrentar a los padres del bully directamente.
    - ○ c. Ayudar a encontrar actividades para construir la autoestima de su niño/a.
    - ○ d. Dar al niño estrategias para resolverlo con el “bully”.
    - ○ e. No lo sé.

12. ¿Qué significa MODEL (un acrónimo para proteger contra “bullying”)?
    - ○ a. Modela relaciones románticas saludables, Observa las interacciones sociales, Discute la intimidación de los hermanos, Fomenta la autoestima, y Eschucha a su niño.
    - ○ b. Haga uso de la comunicación respetuoso, Solo ten cuidado a su hijo/a, Discute el acoso o “bullying” en el hogar, Ten empatía, Escucha a los niños en necesidad.
    - ○ c. Memoriza la definición de “bullying”, Omite “bullying” del hogar, Exige que tu niño no intimide (bully) a otros, Analiza a los amigos de tu niño, Aprende a prevenir el acoso cibernético o “cyber-bullying.”
    - ○ d. Haga uso de la comunicación respetuosa, Observe interacciones sociales, Defina los términos y las experiencias, Capacite a todos los involucrados, Aprenda cómo prevenir del acoso cibernético o “cyber-bullying.”
    - ○ e. No lo sé.

13. ¿Cuál patrón de conocimiento NO está asociado con el uso de la disciplina dura?
    - ○ a. Creyendo que un niño está comportándose mal en propósito.
    - ○ b. Creyendo que un niño debería poder hacer algo que él/ella no está haciendo.
    - ○ c. Pensando de otras explicaciones para el comportamiento del niño.
    - ○ d. Sintiendo desesperanzando e indefenso sobre el futuro.

- e. No lo sé.

14. ¿Cuándo su hijo/a se ha comportado mal y usted está decidiendo cómo disciplinarle, ¿cuál es la primera pregunta que debe hacerse?
    - a. "¿Quién más puede manejar esto?"
    - b. "¿Qué estoy sintiendo en este momento?"
    - c. "¿Por qué él/ella hizo eso?"
    - d. "¿Qué quiero que él/ella aprenda ahora mismo?"
    - e. No lo sé.

15. Cuando usted está discutiendo la prevención del abuso sexual con su niño, usted debe:
    - a. Explicar la función de cada parte privada.
    - b. Usar las palabras para los partes privados que ellos ven en la televisión.
    - c. Explicar el sexo a su niño.
    - d. Utilizar términos anatómicamente correctos.
    - e. No lo sé.

16. Para las aplicaciones para que requiere su hijo/a tenga una contraseña, la cosa más importante es que usted:
    - a. Le pregunta a mi niño mostrarme lo que él/ella hace en el sitio
    - b. Sabe la contraseña y chequea el sitio
    - c. Le cuenta a mi niño a escribir su contraseña en papel así él/ella no la olvida
    - d. Elige la contraseña
    - e. No lo sé.

Child Safe Parent Behavior Questionnaire

Think about the past week and fill in the number of times you have done each of the following. For these questions, “my child” can refer to any of your children or “a child in your life.”

1. I discussed preventing sexual abuse with my child (by talking about their private parts, adults who take care of them, etc.).
   - ○ Never
   - ○ 1 or 2 times
   - ○ 3 or more times

2. I spoke with my child about internet safety.
   - ○ Never
   - ○ 1 or 2 times
   - ○ 3 or more times

3. I examined my child’s technological gadgets and websites they visit.
   - ○ Never
   - ○ 1 or 2 times
   - ○ 3 or more times

4. I asked the staff at a school, camp, or program my child attends about their policies that prevent sexual abuse.
   - ○ Never
   - ○ 1 or 2 times
   - ○ 3 or more times

5. I dropped in unexpectedly or observed another adult who was with my child.
   - ○ Never
   - ○ 1 or 2 times
   - ○ 3 or more times

6. I made sure that multiple adults were present in an activity involving my child.
   - ○ Never
   - ○ 1 or 2 times
   - ○ 3 or more times

7. I talked to another adult about sexual abuse and how to prevent it.
   - ○ Never
   - ○ 1 or 2 times
   - ○ 3 or more times

8. I thought about good times, places, and/or ways to talk to my child about sexual abuse
- ○ Never
- ○ 1 or 2 times
- ○ 3 or more times

9. I used the anatomically correct terms for private parts when speaking with my child.
- ○ Never
- ○ 1 or 2 times
- ○ 3 or more times

10. I learned more about what is typical for my child's age/developmental level.
- ○ Never
- ○ 1 or 2 times
- ○ 3 or more times

11. I challenged myself when I assumed that my child misbehaved on purpose.
- ○ Never
- ○ 1 or 2 times
- ○ 3 or more times

12. In front of my child, I acted like I was calm even though I was anxious or angry
- ○ Never
- ○ 1 or 2 times
- ○ 3 or more times

13. I made a plan as to how to address one of my child's specific behavior problems.
- ○ Never
- ○ 1 or 2 times
- ○ 3 or more times

14. After acting in a way I didn't like with my child, I thought about how I could have handled it better.
- ○ Never
- ○ 1 or 2 times
- ○ 3 or more times

15. I got parenting advice from experts (e.g., pediatrician, teacher) or other resources (e.g., library, internet).
- ○ Never
- ○ 1 or 2 times
- ○ 3 or more times

16. I used a relaxation skill (e.g., deep breathing, mindfulness) to manage my stress.

- ○ Never
- ○ 1 or 2 times
- ○ 3 or more times

17. I asked another adult for help when I was feeling stressed out.
    - ○ Never
    - ○ 1 or 2 times
    - ○ 3 or more times

18. I stopped using my screens/phone at least two hours before going to bed.
    - ○ Never
    - ○ 1 or 2 times
    - ○ 3 or more times

19. I made my child put their screens/technology away during family time.
    - ○ Never
    - ○ 1 or 2 times
    - ○ 3 or more times

20. I pointed out a mistake I made to my child.
    - ○ Never
    - ○ 1 or 2 times
    - ○ 3 or more times

21. I asked my child if s/he has been a victim of or witnessed bullying.
    - ○ Never
    - ○ 1 or 2 times
    - ○ 3 or more times

22. I punished my child for unkind behavior done to other children.
    - ○ Never
    - ○ 1 or 2 times
    - ○ 3 or more times

23. I spoke to my child about how to help another child who is being treated unkindly.
    - ○ Never
    - ○ 1 or 2 times
    - ○ 3 or more times

24. I used Problem Solving to figure out how to better protect my child.
    - ○ Never
    - ○ 1 or 2 times

- ○ 3 or more times

25. I used Considering Alternative Thoughts to figure out how to better protect my child.
    - ○ Never
    - ○ 1 or 2 times
    - ○ 3 or more times

26. I asked my child how they wanted to greet someone.
    - ○ Never
    - ○ 1 or 2 times
    - ○ 3 or more times

27. Specific other actions you have taken to prevent emotional or physical harm to your child or other children:

_____

_____

_____

Cuestionario de comportamiento del padre de Child Safe

Piensa en la última semana y rellena el número de veces que ha hecho cada uno de las siguientes acciones. Para estas preguntas, “mi hijo/a” puede referirse a cualquiera de sus hijos o “un niño en su vida.”

1. He hablado sobre la prevención del abuso sexual con mi hijo/a (al hablar sobre sus partes privadas, los adultos que se ocupan de él/ella, etc.)

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

2. He hablado con un niño/a sobre la seguridad en el internet.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

3. He examinado los aparatos tecnológicos de mi hijo/a y los sitios que visitan.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

4. He preguntado a un empleado en una escuela, campamento, o programa que mi hijo/a asiste sobre sus políticas de prevención del abuso sexual.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

5. He pasado de improviso para observar otro adulto que estaba con mi hijo/a.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

6. Me aseguré de que varios adultos estuvieran presentes en una actividad relacionada con mi hijo/a.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

7. He hablado con otro adulto sobre el abuso sexual y cómo prevenirlo.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

8. He pensado en los buenos tiempos, lugares y /o formas de hablar con mi hijo/a sobre el abuso sexual.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

9. He utilizado los términos anatómicamente correctos para las partes privadas cuando hablo con mi hijo/a.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

10. He aprendido más sobre lo que es típico de la edad/nivel de desarrollo de mi hijo/a.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

11. Me desafié a mí mismo cuando asumí que mi hijo/a se portaba mal a propósito.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

12. En frente de mi hijo/a actué como si estuviera tranquilo, aunque estaba ansioso o enojado.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

13. Hice un plan sobre cómo afrontar uno de los problemas de comportamiento específicos de mi hijo/a.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

14. Después de actuar de una manera que no me gustó con mi hijo/a, pensé en cómo podría haberlo manejado mejor.

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

15. He recibido consejos para padres de expertos (por ejemplo, pediatra, maestra/o) u otros recursos (por ejemplo, biblioteca, internet).

- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

16. He usado una habilidad de relajación (por ejemplo, respiración profunda, concientización) para controlar mi estrés.
- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

17. He preguntado a otro adulto por ayuda cuando me sentía estresado.
- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

18. He dejado de usar mis pantallas/teléfono al menos dos horas antes de irme a la cama.
- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

19. Hice que mi hijo/a guardara sus pantallas/tecnología durante el tiempo de la familia.
- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

20. He señalado un error que cometí con mi hijo/a.
- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

21. He preguntado a mi hijo/a si él/ella había sido víctima o testigo de la intimidación ("bullying").
- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

22. He castigado a mi hijo/a por el comportamiento cruel hecho a otros niños.
- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

23. He hablado con mi hijo/a sobre cómo ayudar a otro niño que está siendo tratado de manera poco amable.
- ○ Nunca

- ○ Una o dos veces
- ○ Tres o más veces

24. He usado la resolución de problemas para descubrir cómo proteger mejor a mi hijo/a.
- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

25. He considerado pensamientos alternativos para descubrir cómo proteger mejor a mi hijo/a.
- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

26. Le pregunté a mi hijo/a cómo querían saludar a alguien.
- ○ Nunca
- ○ Una o dos veces
- ○ Tres o más veces

27. Por favor cuéntenos de otras acciones específicas que ha tomado para prevenir el daño físico o emocional a su hijo/a u otros niños:

_____
_____
_____

Child Safe for Parents Feedback

Please provide your honest feedback to the following questions.

What did you like about the workshop?

_____
_____
_____
_____
_____

What changes would you recommend for the workshop?

_____

_____

_____

_____

_____

Please rate the degree to which you agree or disagree with the following statements about the training:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I found the presentation well organized and easy to follow.	O	O	O	O	O
2. I found the group discussion useful.	O	O	O	O	O
3. I learned new information about child abuse and safety.	O	O	O	O	O
4. I learned new, useful steps for protecting my children	O	O	O	O	O
5. I felt comfortable during the presentation on child sexual abuse.	O	O	O	O	O
6. I felt comfortable during the presentation on losing our cool as parents.	O	O	O	O	O
7. I felt comfortable during the presentation on bullying.	O	O	O	O	O
8. I am likely to use the steps I learned to protect my children.	O	O	O	O	O
9. I am likely to share what I learned with a friend or co-worker.	O	O	O	O	O
10. I am likely to share what I learned with a family member.	O	O	O	O	O

11. Enough resources for emotional support were provided during the training.	O	O	O	O	O

Los cuidadores cuestionario de reacción

Por favor, comparta su honesta opinión en las siguientes preguntas.

¿Qué le gustaba más del taller?

_____

_____

_____

_____

¿Qué recomendaciones tiene para el taller?

_____

_____

_____

_____

Califique cuanto está de acuerdo o en desacuerdo con las siguientes afirmaciones sobre el entrenamiento:

	Fuertemente en desacuerdo	En desacuerdo	No estoy de acuerdo ni en desacuerdo	De acuerdo	Fuertemente de acuerdo
1. He encontrado a la presentación bien organizada y fácil de seguir.	O	O	O	O	O
2. He encontrada a la discusión del grupo útil.	O	O	O	O	O
3. Aprendí información nueva sobre abuso de niños y la seguridad de niños.	O	O	O	O	O
4. Aprendí nuevos y útiles pasos para proteger a mis hijos.	O	O	O	O	O
5. Me sentí cómodo durante la presentación sobre el abuso sexual infantil.	O	O	O	O	O
6. Me sentí cómodo durante la presentación sobre la pérdida de nuestra calma como padres.	O	O	O	O	O

7. Me sentí comodo/a durante la presentación sobre “bullying.”	O	O	O	O	O
8. Es probable que use los pasos que aprendí para proteger a mis hijos.	O	O	O	O	O
9. Es probable que comparta lo que aprendí con un amigo o compañero de trabajo.	O	O	O	O	O
10. Es probable que comparta lo que aprendí con un miembro de la familia.	O	O	O	O	O
11. Se proporcionaron bastantes recursos de apoyo durante la formación.	O	O	O	O	O

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